ALVIN INDEPENDENT SCHOOL DISTRICT

Diabetes Medical Management Plan

Date of Plan: _____ School Year (must be current): _____

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Student's Name: _____ Date of Birth: _____

Date of Diabetes Diagnosis: _____ ☐ Type 1 ☐ Type 2 ☐ Other: _____

School: _____ School Phone Number: _____

Homeroom Teacher: _____ Grade: _____

Contact Information:

Mother/Guardian: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Father/Guardian: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Student's Doctor/Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Emergency Number: _____

FAX Number: _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Notify parents/guardian or emergency contact in the following situations: _____

_____

Blood Glucose Monitoring:

Target range for blood glucose is ☐ 70-130 mg/dL ☐ 70-180 mg/dL ☐ Other: _____

Check blood glucose level: ☐ Before lunch ☐ _____ Hours after lunch ☐ Mid-Morning

Times to do extra blood glucose checks (*check all that apply*)

- ☐ Before physical education/exercise
- ☐ After physical education/exercise
- ☐ 2 hours after a correction dose
- ☐ When student exhibits symptoms of hyperglycemia
- ☐ When student exhibits symptoms of hypoglycemia
- ☐ Other (explain): _____

Can student perform own blood glucose checks? ☐ Yes ☐ No

Exceptions: _____

Type of blood glucose meter student uses: _____

Insulin Therapy:

Insulin delivery device: ☐ syringe ☐ insulin pen ☐ insulin pump

Type of insulin therapy at school:

- ☐ Adjustable Insulin Therapy
- ☐ Fixed Insulin Therapy
- ☐ No insulin

Adjustable Insulin Therapy

Carbohydrate Coverage/Correction Dose:

Name of insulin: _____

Carbohydrate Coverage:

Insulin to Carbohydrate Ratio:

Lunch: 1 unit of insulin per _____ grams of carbohydrate.

Snack: 1 unit of insulin per _____ grams of carbohydrate.

Correction Does:

Blood Glucose Factor/Insulin Sensitivity Factor = _____

Target blood glucose = _____ mg/dL

Correction dose scale (use instead of calculation above to determine insulin correction dose)

Blood glucose _____ to _____ mg/dL – give _____ units.

Blood glucose _____ to _____ mg/dL – give _____ units.

Blood glucose _____ to _____ mg/dL – give _____ units.

Blood glucose _____ to _____ mg/dL – give _____ units.

When to give insulin:

Lunch

- ☐ Carbohydrate coverage only
- ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____mg/dL and _____ hours since the last insulin dose.

Snack

- ☐ No coverage for snack
- ☐ Carbohydrate coverage only
- ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____mg/dL and _____ hours since the last insulin dose.
- ☐ Other: _____

Fixed Insulin Therapy

Name of Insulin: _____

- ☐ _____ Units of insulin given pre-lunch daily
- ☐ _____ Units of insulin given pre-snack daily
- ☐ Other: _____

Parent authorization to Adjust Insulin Dose:

- ☐ Yes ☐ No Parents/guardian authorization should be obtained before administering a correction dose.
- ☐ Yes ☐ No Parents/guardian are authorized to increase or decrease correction dose within the following range: _____ +/- units of insulin.
- ☐ Yes ☐ No Parents/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ units of insulin.
- ☐ Yes ☐ No Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: _____ +/- units of insulin.

Student's self-care insulin administration skill:

☐ Yes ☐ No Independently calculates and gives own injections
☐ Yes ☐ No May calculate/give own injections with supervision
☐ Yes ☐ No Requires school nurse or trained unlicensed diabetes personnel to calculate/give injections

For Students with Insulin Pumps

Type of pump: _____ Type of insulin in pump: _____

Basal rates during school: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Physical Activity:

May disconnect from pump for sports activities: ☐ Yes ☐ No
Set a temporary basal rate: ☐ Yes ☐ No % temporary basal for ____ hours.
Suspend pump use: ☐ Yes ☐ No

Student Pump Abilities/Skills:	**Needs Assistance**	
Count carbohydrates	☐ Yes	☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes	☐ No
Calculate and administer corrective bolus	☐ Yes	☐ No
Calculate and set basal profiles	☐ Yes	☐ No
Calculate and set temporary basal rate	☐ Yes	☐ No
Disconnect pump	☐ Yes	☐ No
Reconnect pump at infusion set	☐ Yes	☐ No
Prepare reservoir and tubing	☐ Yes	☐ No
Insert infusion set	☐ Yes	☐ No
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

Other Diabetes Medications:

Name: _____ Dose: _____ Route: _____ Times given: _____

Name: _____ Dose: _____ Route: _____ Times given: _____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Meal/Snack	*Time*	*Food content/amount*
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____

Snack before exercise? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount: _____

Preferred snack foods: _____

Foods to avoid, if any: _____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

_____

_____

Exercise and Sports

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____ student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____

_____

Treatment of hypoglycemia: _____

_____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. Route _____, Dosage _____, site for glucagon injection: _____arm, _____thigh, _____other. If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia: _____

_____

Treatment of hyperglycemia: _____

_____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____

_____

Signatures:

This Diabetes Medical Management Plan Has Been Approved By:

_____ _____

Student's Physician/Health Care Provider ***Date***

I, _____ (parent/guardian), give permission to the school nurse or another qualified health care professional or a trained unlicensed diabetes care personnel to perform and carry out the diabetes care tasks as outlined in _____ (student's) Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Supplies to be kept at school:

_____Blood glucose meter, blood glucose test strips, batteries for meter
_____Insulin vials and syringes
_____Lancet device, lancets, gloves, etc.
_____Urine ketone strips
_____Insulin pump and supplies
_____Insulin pen, pen needles, insulin cartridges
_____Fast-acting source of glucose
_____Carbohydrate containing snack
_____Glucagon emergency kit

Acknowledged and Received By:

_____ _____

Student's Parent/Guardian *Date*

_____ _____

Student's Parent/Guardian *Date*

_____ _____

School Nurse/Other Qualified Health Care Personnel *Date*