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*