

Avon Lake City Schools
Diabetes Medical Management Plan



Effective Dates _____ Date of Plan _____

Directions: This plan needs to be completed by the student's personal health care team and parent/guardian, and reviewed with relevant school staff. Copies will be kept in a place easily accessible by the school nurse, trained diabetes personnel and other authorized personnel. The parent/guardian is responsible for maintaining supplies, medications and notifying the school nurse of any changes.

Student Information

Name _____

Date of Diabetes Diagnosis _____ Date of Birth _____

Grade/Program _____ Homeroom Teacher _____

Physical Condition: Diabetes Type 1 Diabetes Type 2 Other _____

Transportation: Bus/District # _____ Private Car _____ Walk _____ Other _____

Contact Information

Mother/Guardian Name _____

Address _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian Name _____

Address _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider Information

Name _____

Address _____

Telephone: _____ Emergency Number _____

Other Emergency Contacts

Name _____

Relationship _____

Telephone: Home _____ Work _____ Cell _____

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

Blood Glucose Monitoring

Target range for blood glucose: 70-150 70-180 Other _____

Usual times to check blood glucose _____

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

- Before exercise
- After exercise
- When student exhibits symptoms of hyperglycemia
- When student exhibits symptoms of hypoglycemia
- Other (please explain) _____

Can student perform own blood glucose checks? Yes No

Exceptions: _____

Type of blood glucose meter used by student: _____

Insulin

Usual Lunchtime Dose

Base dose of Humalog/Novolog/Regular insulin at lunch (circle type of rapid-/short-acting insulin used) is _____ units or does flexible dosing using _____ units/_____grams carbohydrate

Use of other insulin at lunch (circle type of insulin used): intermediate/NPH/lente _____ units or basal/Lantus/Ultralente _____ units

Insulin Correction Doses

Parental authorization should be obtained before administering a correction dose for high blood glucose levels.

Yes No

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

Can student give own injections? Yes No

Can student determine correct amount of insulin? Yes No

Can student draw correct dose of insulin? Yes No

Parents are authorized to adjust the insulin dosage under the following circumstances: _____

For Students with Insulin Pumps

Type of pump: _____ Basal rates: _____ 12 a.m. to _____
_____ to _____
_____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ration: _____ Correction factor: _____

Student Pump Abilities/Skills

Needs Assistance

Count carbohydrates	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bolus correct amount for carbohydrates consumed	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Calculate and administer corrective bolus	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Calculate and set basal profiles	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Calculate and set temporary basal rate	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Disconnect pump	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Reconnect pump at infusion set	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Prepare reservoir and tubing	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Insert infusion set	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Troubleshoot alarms and malfunctions	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

For Students Taking Oral Diabetes Medications

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? Yes No

<u>Meal/Snack</u>	<u>Time</u>	<u>Food/content/amount</u>
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

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 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 _____

Glucagons should be given if the student is unconscious, having a seizure (convulsion) or unable to swallow.

Route _____, Dosage _____, site for glucagons injection: _____ arm,
_____ thigh, _____ other.

If glucagons is required, administer it promptly, then call 911 (or other emergency assistance) and the parent/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: _____

Supplies to be kept at School

- | | |
|---|--|
| _____ Blood glucose meter, blood glucose test strips, | _____ Insulin pump and supplies |
| _____ batteries for meter | _____ Insulin pen, pen needles, insulin cartridges |
| _____ Lancet device, lancets, gloves, etc. | _____ Fast-acting source of glucose |
| _____ Urine ketone strips | _____ Carbohydrate-containing snack |
| _____ Insulin vials and syringes | _____ Glucagon emergency kit |

Signatures

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider

Date

I give permission to the school nurse, trained diabetes personnel and other designated staff members of _____ school to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have care of my child and who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

Student's Parent/Guardian

Date

Student's Parent/Guardian

Date