CONROE INDEPENDENT SCHOOL DISTRICT
Committed to Excellence

Diabetes Medical Management Plan

Date of Plan: _____

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.

Effective Dates: _____

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

Contact Information

Mother/Guardian: _____

Address: _____

Telephone: *Home* _____ *Work* _____ *Cell* _____

Father/Guardian: _____

Address: _____

Telephone: *Home* _____ *Work* _____ *Cell* _____

Student's Doctor/Health Care Provider: Name: _____

Address: _____

Telephone: _____ Emergency No.: _____

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 ☐ 70-150 ☐ 70-180 ☐ Other _____

Usual times to check blood glucose _____

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

☐ before exercise ☐ when student exhibits symptoms of hyperglycemia

☐ after exercise ☐ 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

Usual Lunchtime Dose

Base dose of ☐ *Humalog* ☐ *Novolog* ☐ *Regular* insulin at lunch *(check 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
_____ 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 am to _____

_____ _____ to _____

_____ _____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

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

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

Meal/Snack	*Time*	*Food content/amount*
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 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 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: _____

_____

Supplies to be kept at School

- ☐ Blood glucose meter, blood glucose test strips, batteries for meter
- ☐ Lancet device, lancets, gloves, etc.
- ☐ Insulin pen, pen needles, insulin cartridges
- ☐ Carbohydrate containing snack
- ☐ Urine ketone strips
- ☐ Insulin pump and supplies
- ☐ Fast-acting source of glucose
- ☐ 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 custodial 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*

Individualized Health Plan: *Diabetes*

CONROE INDEPENDENT SCHOOL DISTRICT
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Date: _____

Student's name: _____ Grade: _____ Homeroom teacher: _____

Date of Birth: _____ Date/age diagnosed: _____ Diabetes diagnosis: ☐ type 1 ☐ type 2

Parent/Guardian #1: Name _____

Home _____ Work _____ Cell _____

Parent/Guardian #2: Name _____

Home _____ Work _____ Cell _____

Other Contact: Name _____ Phone # _____

Physician _____ Phone # _____

Blood Glucose

Usual times to test glucose at school _____

BG testing *(check any that apply)* ☐ before exercise ☐ after exercise

☐ other *(explain)*: _____

Can student perform own test? ☐ Yes ☐ No

Hypoglycemia

Symptoms: _____

Glucose level mandating treatment if no symptoms _____

Treatment _____

Glucagon *(dose)* _____ Expiration _____

Activity restriction *(if applicable)* _____

Hyperglycemia

Symptoms: _____

Blood glucose to test for ketones _____

Treatment _____

Sliding scale correction dose: _____ units if BG is _____ to _____ mg/dl _____ units if BG is _____ to _____ mg/dl

_____ units if BG is _____ to _____ mg/dl _____ units if BG is _____ to _____ mg/dl

Activity restriction *(if applicable)* _____

Insulin

Time: _____ ☐ a.m. ☐ p.m. Dose _____ by *(check one)* ☐ syringe ☐ pen ☐ pump

Can student give own injections? ☐ Yes ☐ No Supervision required? ☐ Yes ☐ No

Flex insulin dosage: *Insulin type* _____, _____ *units to* _____ *gms carbohydrates*

Insulin pump: *type* _____ *Basal rates* _____ *time* _____ *to* _____ *insulin type* _____

Insulin/carbohydrate ratio _____ Correction factor _____

Insulin type _____ Infusion set _____

Type II Diabetes

Medication: _____ Daily calories _____

Meals and snacks

Times in school: _____

Circumstances requiring parent notification _____

Additional recommendations _____

Emergency health-care plan _____

_____ _____

School nurse *Parent/guardian*

_____ _____

Administrator *Faculty representative*