SPECIAL SCHOOL DISTRICT
HEALTH SERVICES

Diabetes Medical Management Plan

This plan should be completed by the student's personal health care team (physician) 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. **This plan needs to be updated annually prior to the first day of school attendance.**

Student's Name: _____
Date of Birth: _____ Date of Diabetes Diagnosis:_____
Grade:_____ Homeroom Teacher:_____
Physical Condition: Diabetes type 1_____ Diabetes type 2_____ Other_____

Contact Information

Parents:_____
Address:_____
Telephone:
Home_____Work_____Cell_____
Other important
numbers:_____

Student's Health Care Provider

Name: _____
Address:_____
Telephone:_____ Fax_____
Emergency 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 :_____
Usual times to check blood
glucose_____
Times to do extra blood glucose checks: before exercise____, after exercise____, when student exhibits symptoms of high blood sugar____, when student exhibits symptoms of low blood sugar____, other (explain)____.
Can student perform own blood glucose checks?-_____
Exceptions:_____
Type of blood glucose meter student uses:_____

Insulin

Please describe insulin
regimen_____

Insulin Correction dose:

____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

For students with insulin pumps

Type of pump:_____Basal rates:_____12am to_____
_____ _____to _____
_____ _____to _____
Type of insulin in pump:_____
Type of infusion set:_____
Insulin/Carbohydrate ratio:_____Correction factor:_____

Student Pump Abilities/Skills:

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 rates: 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 student taking oral diabetes medications

Type and dosage of medication: _____ Timing: _____
Other medications: _____ Timing: _____
Other medications: _____ Timing: _____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? Yes____No_____
Breakfast: time_____ Food content/amount_____
Mid-morning snack: time_____ Food content/amount_____
Lunch: time_____ Food content/amount_____
Mid-afternoon snack: time_____ Food content/amount_____
Dinner: time_____ Food content/amount_____
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:_____

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:_____thigh or _____other. If glucagon is required, administer promptly *(by the nurse, if no nurse is available, 911 will be called to administer).* Then, call 911 (or other emergency assistance) and then parents/guardian.

Hyperglycemia (High Blood Sugar)
Usual symptoms of hyperglycemia:_____
_____
_____
Treatment of hyperglycemia:_____
_____
_____
Urine should be checked for ketones when blood sugar is above _____mg/dl.
Treatment for ketones:_____
_____
_____

Supplies to be kept at school:
Meter_____ Strips_____Battery for meter_____
lancet device_____lancets_____ketone strips_____Insulin vials, pens_____ syringes_____Insulin pen needles_____insulin cartridges_____insulin pump and supplies_____fast acting source of glucose_____carbohydrate snack_____
Glucagon emergency kit_____

Signatures
This Diabetes Medical Management Plan has been approved by:
Student's 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 release of the information 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.

Student's
Parent/Guardian_____Date_____

Student's
Parent/Guardian_____Date_____

School Nurse _____ Date _____

Adapted from *Diabetes Management in the School Setting* by Special School District 8/11/09.