

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
DIABETES MEDICAL MANAGEMENT PLAN

Page 1 of 5

PART I TO BE COMPLETED BY PARENT OR GUARDIAN

Student _____ Date of Birth _____ Date of Diagnosis _____

School _____ Grade/ Teacher _____

Physical Condition: *check all that apply* Diabetes type 1 Diabetes type 2

Contact Information

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Licensed Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Fax _____ Emergency _____

Emergency Contact other than listed above:

Name: _____ Relationship _____

Telephone: Home _____ Work _____ Cell _____

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

Blood glucose less than _____ mg/dl Blood glucose greater than _____ mg/dl

Insulin pump problems Vomiting or feeling ill

Presence of urine ketones

Other: _____

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROFESSIONAL

BLOOD GLUCOSE MONITORING

Type of blood glucose meter student uses: _____

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

Usual times to check blood glucose _____

(Blood Glucose Monitoring continued)

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

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

Can student perform own blood glucose checks? Yes No

Exceptions: _____

Student may test discreetly in the classroom setting Yes No

Student must test in the school health room Yes No

Blood Glucose Management

Refer to appropriate treatments as indicated on Parts A and B Quick Reference Emergency Plan

FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS

Administration of medications during school-sanctioned activities requires complete appropriate Medication Authorization forms

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

INSULIN

Administration of insulin during school-sanctioned activities requires complete appropriate Medication Authorization forms.

Type of insulin therapy at school

- Adjustable Insulin
- Fixed Insulin
- No insulin

Usual Lunchtime Dose

Base dose _____ (name of insulin) _____ units by _____ (route)

Insulin Correction Doses

Parental authorization required before administering a correction dose for high blood glucose levels.

- Yes
- No

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

$\frac{\text{Grams of Carb in meal}}{\text{Insulin to Carb ratio}}$	=	___ units of insulin
---	---	----------------------

Correction Dose

Blood glucose correction factor / insulin sensitivity factor = _____

Target blood glucose = _____

$\frac{\text{Actual blood glucose} - \text{Target blood glucose}}{\text{Blood glucose correction factor/insulin sensitivity factor}}$	=	___ units of insulin
---	---	----------------------

- _____ 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 PENS

Type of pen: _____

Insulin / carbohydrate ratio: _____

Correction factor: _____

Special instructions, if any: _____

FOR STUDENTS WITH INSULIN PUMPS

Brand/Model of pump: _____ Basal rates: _____ 12 am to _____

_____ to _____

_____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____

Correction factor: _____

Special instructions if any: _____

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

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

Check blood glucose levels prior to PE/activity _____ Yes _____ No
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.

Student will carry a fast-acting carbohydrate such as _____ to the site of exercise.

Restrictions on activity, if any: _____

Other considerations: _____

HYPOGLYCEMIA (Low Blood Sugar)

Complete Part A of Diabetes Medical Management Plan

Usual symptoms of hypoglycemia: _____

Treatment of hypoglycemia: _____

GLUCAGON ADMINISTRATION

Administration of Glucagon during school sanctioned activities requires complete appropriate Medication Authorization forms

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

Route IM Dosage _____ Site: arm thigh other.

If Glucagon is required, administer it promptly. Call 911 and the parents/guardian.

HYPERGLYCEMIA (High Blood Sugar)

Complete Part B of Diabetes Medical Management Plan

Usual symptoms of hyperglycemia: _____

Treatment of hyperglycemia: _____

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

Treatment for ketones: _____

For blood glucose greater than _____ mg/dl. **AND** at least _____ hours since last insulin dose give correction dose of insulin as noted on page 2.

DISASTER PLANNING

Special considerations, if any, to prepare for an unplanned disaster or emergency (72 hours).

Requires emergency supply kit from parent / guardian

OTHER CONSIDERATIONS FOR THE PLAN

PARENTAL PROVIDED SUPPLIES TO BE KEPT AT SCHOOL

- Blood glucose meter and test strips
- Batteries for meter
- Lancet device and lancets
- Urine ketone strips
- Insulin vials and syringes
- Insulin pump
- Batteries for pump
- Infusion set and supplies
- Insulin pen, pen needles, insulin cartridges
- Fast-acting source of glucose
- Carbohydrate containing snack
- Glucagon emergency kit
- 3 days supply of food and drink (disaster preparedness)
- 3 days supply of insulin and syringes (disaster preparedness)

Signatures and Authorizations

This Diabetes Medical Management Plan has been formulated and approved by:

Licensed Health Care Provider

Telephone

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 in _____'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. I hereby request school personnel to administer the ordered medications and treatments as prescribed in this Office of Catholic Schools Diocese of Arlington Diabetes Medical Management Plan. I agree to release, indemnify and hold harmless the designated school personnel or agents from lawsuits, claim expense, demand or action etc. against them for administering these injections /treatments provided the designated school personnel comply with the LHCP or orders as set forth above. I am aware that these injections / treatments may be administered by a specifically trained non- health professional. I have read the procedure outlined on this form and assume responsibility as required.

Acknowledged and received by:

Parent/Guardian

Date

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL

- | | | | | | | | | |
|---|-------------|-----|----|-----|--------------|-----|----|-----|
| • Diabetes Medical Management Plan pages 1-5 completed | | yes | | no | | | | |
| • Quick Reference Emergency Plan Part A and B completed | | yes | | no | | | | |
| • Medication authorization complete | | yes | | no | | | | |
| • Medication maintained in school-designated area | | yes | | no | | | | |
| • Expiration date of medication (s) | | | | | | | | |
| • Parental provided supplies maintained in school | | yes | | no | | | | |
| • Staff trained in medication administration | | yes | | no | | | | |
| • Staff trained in Diabetes education | | yes | | no | | | | |
| • Copies of plan provided to: | Educational | yes | no | n/a | After school | yes | no | n/a |
| | Athletic | yes | no | n/a | Food service | yes | no | n/a |

Full Diabetes Action Plan has been implemented

Principal or Registered Nurse

Date