OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON DIABETES MEDICAL MANAGEMENT PLAN

Page 1 of 5 TO BE COMPLETED BY PARENT OR GUARDIAN PART I Date of Birth _____ Date of Diagnosis _____ Student School Grade/ Teacher Physical Condition: *check all that apply* □ Diabetes type 1 □ Diabetes type 2 **Contact Information** Mother/Guardian: Address: Work _____ Cell ____ Telephone: Home Father/Guardian: Address: Home _____ Work ____ Cell____ Telephone: **Licensed Health Care Provider:** Name: Address: _____ Fax _____ Emergency_____ Telephone: **Emergency Contact other than listed above:** Name: Relationship _____ Work _____ Cell ____ Telephone: Home ____ 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				

	Page 2	
(Blood Glucose Monitoring continued)		
Times to do extra blood glucose checks (check all th	nat apply)	
☐Before exercise	□ After exercise	
		□When student exhibits symptoms of hypoglycemia
☐Other (explain):		
Can student perform own blood glucose checks? Exceptions:		
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 of	on Parts A	and B Ouick Reference Emergency Plan
FOR STUDENTS TAKING ORAL DIAB		
Administration of medications during school-sanctioned activity		
Type of medication:Other medications:		Timing:
Other medications.		1 mmg
INSULIN		
Administration of insulin during school-sanctioned activities	requires con	mplete appropriate Medication Authorization forms.
Type of insulin therapy at school		
□Adjustable Insulin □Fixed Insulin	\Box 1	No insulin
Usual Lunchtime Dose		
Base dose	ur	nits by(route)
(name of mount)	un	ints by(route)
Insulin Correction Doses		
Parental authorization required before admin	istering a	correction dose for high blood glucose levels.
$\Box Yes \Box No$		
	Coverage	/ Correction Dose
Name of insulin	ratio	Grams of Carb in meal = units of insulin
Lunch: 1 unit of insulin per grams of		
Snack: 1 unit of insulin per grams of	carbohydra	ate
Correction Dose	our oonly un	
Blood glucose correction factor / insulin sensitivity f	factor =	
Target blood glucose =		Actual blood glucose – Target blood glucose = units of
		Blood glucose correction factor/insulin insulin
 units if blood glucose is to 	mg/dl	sensitivity factor
 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	\Box No
Can student determine correct amount of insulin?	□Yes	□No
Can student draw correct dose of insulin?	□Yes	□No
2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2		—-·· ·
Parents are authorized to adjust the insulin dosage u	ınder the fo	ollowing circumstances

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FOR STUDENTS WITH INSULIN PENS

Type of pen:						
nsulin / carbohydrate ratio:		Correction factor:				
FOR STUDENTS WITH INS	ULIN PUMPS					
Brand/Model of pump:		Basal rates:	12	2 am to		
				to		
Type of insulin in numn				to		
Type of insulin in pump: Type of infusion set:						
nsulin/carbohydrate ratio:		Correction fac	ctor:			
Special instructions if any:						
Student Pump Abilities/Skill	· ·		Needs As	sistanco		
Count carbohydrates	.		Yes	No		
Bolus correct amount for carl	oohvdrates consume	ed	Yes			
	Calculate and administer corrective bolus			No		
Calculate and set basal profil		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 EAT	EN AT SCHOO	<u>DL</u>				
s student independent in carbohydra	te calculations and	management?	\Box Yes	\Box No		
<i>Meal/Snack</i> Breakfast	Time		Fo	ood content/amount		
Mid-morning snack						
Lunch						
Mid-afternoon snack		· · · · · · · · · · · · · · · · · · ·				
Dinner						
Snack before exercise?	□Yes	□No				
Snack after exercise?	□Yes	□No				
Other times to give snacks and conte						
Preferred snack foods:						
roods to avoid, if any:	1, ,1 1 (4 C 1	, <u>C</u>	11:		

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EXERCISE AND SPORTS

Check blood glucose levels prior to PE/activity	Yes _	No	
Student should not exercise if blood glucose level is below	V	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:			
Other considerations.			
HYPOGLYCEMIA (Low Blood Sugar)			
Complete Part A of Diabetes Medical Management Pla	n		
Usual symptoms of hypoglycemia:			
Treatment of hypoglycomia:			
GLUCAGON ADMINISTRATION			
Administration of Glucagon during school sanctioned activities requ	ires comp	lete appropriate Medication 2	Authorization forms
Glucagon is to be given if the student is unconscio			
RouteIM Dosage	Site: [□arm □thigh □	other.
If Glucagon is required, administer it promptly	. Call 9)11 and the parents/	guardian.
		•	O
HYPERGLYCEMIA (High Blood Sugar)			
Complete Part B of Diabetes Medical Management Pla	n		
•			
Usual symptoms of hyperglycemia:			
Treatment of hyperglycemia:			
Urine should be checked for ketones when blood g	lucose le	vels are above	_ mg/dl.
Treatment for ketones:	ID 41	1 1 1	4 . 1. 1 .
For blood glucose greater than mg/dl. AN correction dose of insulin as noted on page 2.	ND at lea	st hours since la	st insulin dose give
DISASTER PLANNING			
Special considerations, if any, to prepare for an unp	olanned o	disaster or emergency (72	2 hours).
Requires emergency supply kit from parent / guard			,
OTHER CONSIDERATIONS FOR THE PLA	<u>N</u>		

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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

Guide for School Personnel. NIH Publication No. 03-5217,

Licensed Health Care Provider

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

I give permission to the school nurse, trained di				designated staff me carry out the dia			s as outlin	ned in
's Diahetes Me				also consent to the re				
in this Diabetes Medical Management Plan to a may need to know this information to maintain ordered medications and treatments as prescri Management Plan. I agree to release, indemni claim expense, demand or action etc. against the personnel comply with the LHCP or orders as s by a specifically trained non- health profession required. Acknowledged and received by:	all staf my ch bed in fy and tem for et fortl	If membild's heat this Of hold her adminithat the above.	ers and othe alth and safe fice of Catharmless the stering these I am aware	r adults who have cuty. I hereby request nolic Schools Dioces designated school per injections /treatment that these injections	school p se of Ar ersonnel ats provi	care of received and expenses of the care	my child and to administ Diabetes Monts from law designated sy be admini	d who ter the ledical wsuits school istered
Training with the reservoir and a great state of the stat								
Parent/Guardian				Date				
1 archy Guardian			•	Jacc				
PART III TO BE COMPLETED					ED NU	RSE		
ACTION P	LAN CI	HECK LI	ST FOR SCH	OOL PERSONNEL				
Diabetes Medical Management Plan pages 1-5 c	omplete	rd.		yes	no			
Quick Reference Emergency Plan Part A and B				yes	no			
Medication authorization complete				yes	no			
Medication maintained in school-designated area				yes	no			
• Expiration date of medication (s)								
- December 11 to a Proportion of the selection								
Parental provided supplies maintained in school				yes	no			
 Staff trained in medication administration Staff trained in Diabetes education 				yes	no			
 Staff trained in Diabetes education Copies of plan provided to: Educational 	N/OC	no	n/a	yes After school	no	no	n/a	
Athletic	yes yes	no no	n/a n/a	Food service	yes yes	no no	n/a	
Full Diabetes Action Plan has been implemented	yes	110	11/ α	1 ood service	yes	110	11/ α	
D'. ' -1 D ' / 1M			- D. /					
Principal or Registered Nurse			Date					

Source: U.S. Department of Health and Human Resources, National Diabetes Education Program. (2010). Helping the Student with Diabetes Succeed: A

Telephone

Date