

Medical Management Plan of Care for Diabetes
Green River District School Health Program

Student: _____ Date of Birth: _____

Date: _____

School: _____

Physician(s): _____

CONTACT INFORMATION:

Parent/guardian #1

Name: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Parent/guardian #2

Name: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Student's Doctor/Health Care Providers:

Doctor: _____

Address: _____

Telephone: _____

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 is _____ mg/dl to _____ mg/dl

Usual time to test blood glucose: _____

Times to do extra blood glucose tests (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 test? Yes No

Insulin

Types, times, and dosage of insulin injections to be given at school:

Time	Type	Dosage
_____	_____	_____
_____	_____	_____

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 |

Can student troubleshoot problems (e.g., ketosis, pump malfunction)? Yes No

Comments: _____

For students taking oral diabetes medications

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Meals and snacks

Is student independent in carbohydrate calculations and management? Yes No

<i>Meal/snack</i>	<i>Time</i>	<i>Food content/amount</i>
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____
Snack before exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Snack after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bedtime snack	<input type="checkbox"/> Yes <input type="checkbox"/> No	

A source of glucose such as _____ should be readily available at all times.

Preferred snack foods: _____

Foods to avoid, if any: _____

Exercise and sports

A snack such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____

Student should not exercise if blood sugar level is below _____ mg/dl or above _____ mg/dl

Hypoglycemia (Low blood sugar)

Usual symptoms of hypoglycemia:

Treatment for hypoglycemia:

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. If glucagon is required, it should be administered promptly. Then, 911 and the parent/guardian called.

Hyperglycemia (High blood sugar)

Usual symptoms of hyperglycemia:

Treatment of hyperglycemia:

Circumstances when urine ketones should be tested:

Treatment for ketones:

SIGNATURES

This diabetes medical management plan has been approved by:

Physician

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 may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

Student's parent/guardian

Date

School Health Personnel

Date