

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON  
DIABETES MEDICAL MANAGEMENT PLAN

Appendix F-5A

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**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 Contacts:**

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

Type of blood glucose meter student uses: \_\_\_\_\_

**Blood glucose Management**

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

**FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS**

Type of medication: \_\_\_\_\_ Timing: \_\_\_\_\_

Other medications: \_\_\_\_\_ Timing: \_\_\_\_\_

**INSULIN**

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

**Usual Lunchtime Dose**

Base dose of, (*select appropriate type*)

<b>Regular</b>	insulin is _____ Units.	<b>Intermediate</b>	insulin is _____ Units.	<b>Basal</b>	insulin is _____ Units.
<b>Novolog</b>	insulin is _____ Units.	<b>NPH</b>	insulin is _____ Units.	<b>Lantus</b>	insulin is _____ Units.
<b>Humalog</b>	insulin is _____ Units.	<b>Lente</b>	insulin is _____ Units.	<b>Ultralente</b>	insulin is _____ Units.

**Insulin Correction Doses**

Parental authorization required 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 PENS**

Type of pen: \_\_\_\_\_

Insulin / carbohydrate ratio: \_\_\_\_\_

Correction factor: \_\_\_\_\_

Special instructions, if any: \_\_\_\_\_  
 \_\_\_\_\_

**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: \_\_\_\_\_

Special instructions if any: \_\_\_\_\_  
 \_\_\_\_\_

***Student Pump Abilities/Skills***

- Count carbohydrates
- Bolus correct amount for carbohydrates consumed
- Calculate and administer corrective bolus
- Calculate and set basal profiles
- Calculate and set temporary basal rate
- Disconnect pump
- Reconnect pump at infusion set
- Prepare reservoir and tubing
- Insert infusion set
- Troubleshoot alarms and malfunctions

***Needs Assistance***

- |     |    |
|-----|----|
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| 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 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 \_\_\_\_\_ 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: \_\_\_\_\_

**DISASTER PLANNING**

Special considerations, if any

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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)

**Signatures**

**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 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:**

\_\_\_\_\_  
 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 \_\_\_\_\_  
 Source: U.S. Department of Health and Human Resources, National Diabetes Education Program. (June 2003). *Helping the Student with Diabetes Succeed: A Guide for School Personnel*. NIH Publication No. 03-5217,