# OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON
# DIABETES MEDICAL MANAGEMENT PLAN

CSO/07-H4



## 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 _________________________________Other 70-180 70-150
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)
Regular insulin is _____ Units. Intermediate insulin is _____ Units. Basal insulin is _____ Units.

Novolog insulin is _____ Units. NPH insulin is _____ Units. Lantus insulin is _____ Units.
Humalog insulin is _____ Units. Lente insulin is _____ Units. Ultralente 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*** | ***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 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
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/or 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. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the plan to be carried out for the student as requested herein, I agree to indemnify and hold harmless the Diocese of Charleston, its servants, agents, and employees, including, but not limited to the parish, school, the principal, and the individuals carrying out the plan, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the carrying out of the plan or failing to carry out the plan for the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Diocese of Charleston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to carry out the plan.

**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: US 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