

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON
DIABETES MEDICAL MANAGEMENT PLAN

CSO/07-H4

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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 _____ 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
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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
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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 |
| Athletic | yes | no | n/a |
| | | | After school yes no n/a |
| | | | Food service yes no n/a |

Full Diabetes Action Plan has been implemented

Principal or Registered Nurse	Date
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