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* 2 epyt setebaiD 1 epyt setebaiD

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 _____rehtO 081-07 051-07
Usual times to check blood glucose _____

(Blood Glucose Monitoring continued)

Times to do extra blood glucose checks (*check all that apply*)

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esicrexe retfA
aimecylgrepyh fo smotpmys stibihxe tneduts nehW
aimecylgopyh fo smotpmys stibihxe tneduts nehW
_____ :)nialpxe(rehtO

Can student perform own blood glucose checks? oN seY
Exceptions: _____
Student may test discreetly in the classroom setting YesNo
Student must test in the school health room YesNo
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.
oN seY

- _____ 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? oN seY
Can student determine correct amount of insulin? oNseY
Can student draw correct dose of insulin? oN seY

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

MEALS AND SNACKS EATEN AT SCHOOL

Is student independent in carbohydrate calculations and management? oN seY

Meal/Snack	***Time***	***Food content/amount***
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

Snack before exercise? oN seY
Snack after exercise? oN seY
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 YesNo
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.

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Route_____ Dosage_____ Site: .rehto hgiht mra

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

spirts tset dna retem esoculg doolB
retem rof seirettaB
stecnal dna ecived tecnaL
spirts enotek enirU
segnirys dna slaiv nilusnI
pmup nilusnI
pmup rof seirettaB
seilppus dna tes noisufnI
segdirtrac nilusni ,seldeen nep ,nep nilusnI
esoculg fo ecruos gnitca-tsaF
kcans gniniatnoc etardyhobraC
tik ycnegreme nogaculG
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: 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,