

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON  
DIABETES MEDICAL MANAGEMENT PLAN

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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 Contact other than listed above:**

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

**Blood Glucose Management**

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

**FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS**

*Administration of medications during school-sanctioned activities requires complete appropriate Medication Authorization forms*

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

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

**INSULIN**

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

**Type of insulin therapy at school**

- Adjustable Insulin
- Fixed Insulin
- No insulin

**Usual Lunchtime Dose**

Base dose \_\_\_\_\_ (name of insulin) \_\_\_\_\_ units by \_\_\_\_\_ (route)

**Insulin Correction Doses**

Parental authorization required before administering a correction dose for high blood glucose levels.

- Yes
- No

**Carbohydrate Coverage / Correction Dose**

Name of insulin \_\_\_\_\_

**Carbohydrate Coverage** / Insulin to Carbohydrate ratio

Lunch: 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

Snack: 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

$\frac{\text{Grams of Carb in meal}}{\text{Insulin to Carb ratio}}$	=	___ units of insulin
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**Correction Dose**

Blood glucose correction factor / insulin sensitivity factor = \_\_\_\_\_

Target blood glucose = \_\_\_\_\_

$\frac{\text{Actual blood glucose} - \text{Target blood glucose}}{\text{Blood glucose correction factor/insulin sensitivity factor}}$	=	___ units of insulin
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- \_\_\_\_\_ 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**

Brand/Model 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**

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

For blood glucose greater than \_\_\_\_\_ mg/dl. **AND** at least \_\_\_\_\_ hours since last insulin dose give correction dose of insulin as noted on page 2.

**DISASTER PLANNING**

Special considerations, if any, to prepare for an unplanned disaster or emergency (72 hours).

Requires emergency supply kit from parent / guardian

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

**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)
- 3 days supply of insulin and syringes (disaster preparedness)

**Signatures and Authorizations**

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 in \_\_\_\_\_'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. I hereby request school personnel to administer the ordered medications and treatments as prescribed in this Office of Catholic Schools Diocese of Arlington Diabetes Medical Management Plan. I agree to release, indemnify and hold harmless the designated school personnel or agents from lawsuits, claim expense, demand or action etc. against them for administering these injections /treatments provided the designated school personnel comply with the LHCP or orders as set forth above. I am aware that these injections / treatments may be administered by a specifically trained non- health professional. I have read the procedure outlined on this form and assume responsibility as required.

**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**