St. Francis Area Schools
4115 Ambassador Boulevard NW, St. Francis, MN 55070
763-753-7040 • www.isd15.org

Diabetes Medical Management Plan

Effective dates _____

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse and/or health service staff.

Student's Name _____

Date of Birth _____ Date of Diabetes Diagnosis _____

Grade_____ Homeroom Teacher _____

Physical Condition: ☐ Diabetes Type I ☐ Diabetes Type II

CONTACT INFORMATION

Mother/Guardian _____

Address _____

Home Phone _____ Work Phone_____ Cell Phone _____

Father/Guardian _____

Address _____

Home Phone _____ Work Phone_____ Cell Phone _____

STUDENT'S HEALTH CARE PROVIDER

Name_____

Address _____

Telephone _____ Emergency Number_____

OTHER EMERGENCY CONTACTS

Name_____ Relationship _____

Home Phone _____ Work Phone_____ Cell Phone _____

Notify parents/guardians of emergency contact in the following situations

_____

_____

Target range for blood glucose is ☐ 70-150 ☐ 70-180 ☐ Other _____

Usual times to check blood glucose_____

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_____

Type of blood glucose meter student uses: _____

INSULIN

Usual Lunchtime Dose

Base does of Humalog/Novolog/Regular insulin at lunch *(circle type of rapid/short acting insulin used)*

is _____ units or does flexible dosing using _____ units/ _____ grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente _____ units or

basal/Lantus/Ultralente _____ units.

Insulin Correction Doses

Parental authorization should be obtained 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 Pumps

Type of pump_____Basal rates _____ 12:00 a.m. to_____

_____ to _____

_____ to _____

Type of insulin pump _____

Type of infusion set_____

Insulin/Carbohydrate ratio _____ Correction factor_____

Diabetes

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 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

For Students Taking Oral Diabetes Medications

Type of medication _____ Timing _____

Other medications_____ Timing _____

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

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any _____

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.

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia_____

_____

Treatment of hypoglycemia_____

_____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route _____ Dosage _____

Site for glucagon injection ☐ Arm ☐ Thigh ☐ Other _____

If glucagons is required, administer it promptly. Then call 911 (or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia _____

_____

Treatment of hyperglycemia _____

_____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones _____

Supplies to be Kept at School

- ☐ Blood glucose meter, blood glucose test strips, batteries for meter
- ☐ Glucagon emergency kit
- ☐ Lancet device, lancets, gloves, etc.
- ☐ Fast-acting source of glucose
- ☐ Urine ketone strips
- ☐ Insulin pen, pen needles, insulin cartridges
- ☐ Insulin vials and syringes
- ☐ Insulin pump and supplies

SIGNATURES

This Diabetes Medical Management Plan has been approved by

_____ _____

Health Care Provider Date

I give permission to the licensed school nurse, health EA or other designated staff members of _____

school to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Management plan and as delegated by the licensed school nurse. 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.

_____ _____

Student's Parent/Guardian Date