Attn: School Nurse
P.O. Box 3129
Montrose, MI 48457

Montrose Community Schools
Preparing our community for life long learning

810-591-8880
810-591-8870
Fax: 810-591-7283

American Diabetes Association
Cure • Care • Commitment

Diabetes Medical Management Plan

Date of Plan: ______________

This plan should be completed by the student's physician and parent / 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, trained diabetes personnel, and other authorized personnel.

Effective Dates: ______________________________

Student's Name: ______________________________

Date of Birth: ______________ Date of Diabetes Diagnosis: ______________

Grade: ______________ Homeroorn Teacher: ______________

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

Contact Information:

Parent / Guardian: ______________________________

Address: ______________________________

____

Telephone: Home ______________ Work ______________ Cell ______________

Student's Physician / Health Care Provider:

Name: ______________________________

Address: ______________________________

Telephone: ______________ Emergency Number: ______________

Other Emergency Contacts:

Name: ______________________________

Relationship: ______________________________

Telephone: Home ______________ Work ______________ Cell ______________

Notify parents / guardian or emergency contact in the following situations:

____
____
____
____

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Blood Glucose Monitoring:

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 (circle type of insulin used)

Rapid / short-acting insulin: Humalog Novolog Other __________

_____ units or flexible dosing using _____ units / _____ grams carbohydrate

Intermediate insulin: NPH Lente Other_____________ _____ units

Long acting insulin: Lantus Ultralente Other __________ _____ 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

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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: _____ Time: 12 am to ______
_____ Time: _____ to _____
_____ Time: _____ to _____

Type of insulin in pump: ____
Type of infusion set: ____
Insulin / carbohydrate ratio: ________________________ Correction factor: ______________

Student Pump AbilitieslSkills:	*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

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

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Meal / Snack	*Time*	*Food content / amount*
Breakfast	______________________	________________________________
Mid-moming snack	______________________	________________________________
Lunch	______________________	________________________________
Mid-aftemoon 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.

Dosage _______ Site for glucagon injection: arm thigh other_____________

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

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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

_______ Lancet device, lancets, gloves, etc.

_______Urine / blood ketone strips

_______Insulin pump and supplies

_______Insulin pen, pen needles, insulin cartridges

_______Fast-acting source of glucose

_______Carbohydrate containing snack

_______Glucagon emergency kit

Signatures:

This Diabetes Medical Management Plan has been approved by:

______________________________ ______________________

Student's Physician / Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members to perform and carry out the diabetes care tasks as outlined by the 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.

Acknowledged and received by:

______________________________ ______________________

Student's Parent/Guardian Date