Children's
HOSPITAL & MEDICAL CENTER
We know children

patient education program

8200 Dodge Street Omaha, NE 68114-4113 402-955-5400 ChildrensOmaha.org

Diabetes Medical Management Plan Worksheet

Date of Plan: _____ Valid for school year: _____ — _____

This plan should be completed by the student's health care team and parent/guardian. It should be reviewed with all relevant school/daycare staff and be kept in a place that is easily accessible by those individuals for who it is necessary.

Student's Name: _____ Birth date: _____

Date of Diabetes Diagnosis: _____ ☐ Type 1 ☐ Type 2 Other: _____

Grade: _____ Homeroom Teacher: _____

Contact Information:

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Diabetes Doctor: _____

Address: __ 8200 Dodge St. Omaha, NE 68114 _____ Telephone: __402-955-3871_____

Other Emergency Contacts:

Name: _____ Relationship: _____

Telephone: Home _____ Work _____ Cell _____

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

Checking student's blood glucose/sugar:

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

Usual times to check blood glucose: _____

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

☐ Before exercise/Physical Education

☐ After exercise/Physical Education

☐ When student has signs/symptoms of low or high blood glucose

☐ When student has signs/symptoms of illness

Can student perform own blood glucose checks? ☐ Yes ☐ No

Exceptions: _____

Type of blood glucose meter student uses: _____

Hypoglycemia (Low blood sugar) Treatment:

Student's usual symptoms of hypoglycemia (list below): _____

_____

Treatment of hypoglycemia: _____

_____

If blood sugar is less than 70 / 80 (circle one) the student should recheck his/her blood sugar in 15 minutes after treatment and continue to treat until blood sugar is over 70 / 80.

Glucagon should be given if the student is unconscious, having a seizure (convulsions), or unable to swallow.
Route: _____; Dose: _____; Site for glucagon injection: ☐ Arm ☐ Thigh ☐ Other_____

If a glucagon dose is required, administer it immediately. Then call 911 (or other emergency assistance) and then parent(s)/guardian(s).

Hyperglycemia (High blood sugar) Treatment:

Student's usual symptoms of hyperglycemia (list below): _____

_____

Treatment of hyperglycemia: _____

_____

Urine/blood should be checked for ketones when blood glucose levels are above 240 mg/dl.

If urine ketones present, push sugar-free fluids and call parent/guardian. Continue to have student check for ketones every time he/she uses the bathroom.

Additional Treatment for ketones: _____

Insulin Therapy:

Name of student's Insulin: _____

Student's Insulin dosing for breakfast/lunch/supper (circle one):

☐ Adjustable Insulin Therapy

☐ Fixed Insulin Therapy

Adjustable Insulin Therapy:

Insulin to Carbohydrate Ratio: 1 unit of insulin per _____ grams of carbohydrate

Calculation Example:
Grams of carbohydrate student is going to eat / Insulin-to carbohydrate ration = _____ units of insulin

Correction Factor: ____ unit for every _____ mg/dl of blood sugar over _____ mg/dl.

Calculation Example:
1. *Student's blood glucose – target blood glucose*
2. *Divide answer from #1 by student's correction factor*
3. *Multiply answer from #2 by student's dose*
4. *Add answer (units of insulin) to answer from insulin to carbohydrate ratio and round as appropriate.*

Student's Insulin dosing for breakfast/lunch/supper (circle one):

☐ Adjustable Insulin Therapy

☐ Fixed Insulin Therapy

Adjustable Insulin Therapy:

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Student's Insulin dosing for breakfast/lunch/supper (circle one):

☐ Adjustable Insulin Therapy

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Adjustable Insulin Therapy:

Insulin to Carbohydrate Ratio: 1 unit of insulin per _____ grams of carbohydrate

Calculation Example:
Grams of carbohydrate student is going to eat / Insulin-to carbohydrate ration = _____ units of insulin

Correction Factor: ____ unit for every _____ mg/dl of blood sugar over _____ mg/dl.

Calculation Example:
1. *Student's blood glucose – target blood glucose*
2. *Divide answer from #1 by student's correction factor*
3. *Multiply answer from #2 by student's dose*
4. *Add answer (units of insulin) to answer from insulin to carbohydrate ratio and round as appropriate*

Fixed Insulin Therapy:

____ Units of insulin given before breakfast daily

____ Units of insulin given before lunch daily

____ Units of insulin given before supper daily

Can student give own insulin injections? ☐ Yes ☐ No

Can student determine correct amount of insulin? ☐ Yes ☐ No

Can student draw up correct dose of insulin? ☐ Yes ☐ No

Parents are authorized to adjust the insulin dosage under the following circumstances: _____

_____

Meal Plan:

Meal/Snack	Time	Number of Carbohydrates
Breakfast	_____	_____
Mid-Morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Supper	_____	_____

Other times to give snacks and content/amount: _____

Instructions for when food is provided to the class (for example, as part of a class party): _____

_____

Can student be independent in carbohydrate calculations and management? ☐ Yes ☐ No

Physical Activity and Sports:

A fast-acting source of sugar such as glucose tabs and/or sugar-containing fluids must be available at the site of physical education activities and sports.

Blood sugar should be at least _____ prior to starting PE or sports if duration of activity is 30 minutes or more.

Student should eat a snack of _____ grams prior to exercise when _____.

If most recent blood sugar is _____ or if urine/blood ketones are present, student should avoid physical activity.

Supplies to be kept at school

- ☐ Blood glucose meter, blood glucose test strips, batteries for meter
- ☐ Lancet device, lancets, gloves, etc.
- ☐ Urine ketone strips
- ☐ Blood ketone meter and blood ketone strips
- ☐ Insulin pen, pen needles, insulin cartridges
- ☐ Fact-acting source of glucose
- ☐ Carbohydrate containing snack
- ☐ Glucagon emergency kit

This Diabetes Medical Management Plan has been approved by:

I, (parent/guardian) give permission to the school nurse or another qualified health care professional or trained diabetes personnel 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 school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider. This form is to be used together with the Endocrine Clinic permission to treat/orders.

Acknowledged and received by:

_____

Student's Parent/Guardian Date

_____

Student's Parent/Guardian Date

_____

School Nurse/Other Qualified Health Care Personnel Date

Reference: Diabetes Medical Management Plan. American Diabetes Association. www.YourDiabetesInfo.org.

Written 10/11