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: 8552 Cass 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: _____

_____

Blood Sugar Monitoring:

Target range for blood glucose: ☐ 70-150 ☐ 80-180 ☐ Other: _____

Usual times to check blood glucose: ☐ Before meals ☐ 2-3 hours after meals

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

☐ Before exercise/physical education of 30 minutes or longer in duration

☐ After exercise/physical education of 30 minutes or longer in duration

☐ Before any bus rides

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

☐ When student has signs/symptoms of illness

☐ Other times to check:_____

Can student perform own blood glucose checks? ☐ Yes ☐ Yes, with supervision ☐ No

Exceptions: _____

Type of blood glucose meter student uses: _____

Continuous Glucose Monitor (CGM):

☐ Yes, brand/model:_____ ☐ No

Use for insulin dosing per parent instruction: ☐ Yes ☐ No

Alarm set for: Severe Low: _____ Low: _____ High: _____ Other: _____

Low Blood Sugar (Hypoglycemia) Treatment:

Student's usual symptoms of low blood sugar (list below): _____

_____

Treatment of low blood sugars: If blood sugar is less than 70/80/other:_____ *(circle one)* the student should be given a quick acting glucose product equal to _____ grams of carbohydrate, recheck his/her blood sugar 15 minutes following the treatment and continue to treat until blood sugar is over 70/80/other:_____. Then give an additional _____ gram carbohydrate snack if the next meal or snack is over an hour away.

If blood sugar is less than 50, double the above treatment amount and then follow same procedure above.

Additional Treatment: _____

Treatment of severe low blood sugars: Glucagon or Baqsimi should be given if the student is unconscious, having a seizure (convulsions), or unable to swallow.

Route: IM/intranasal *(circle one)* Dose: ___mg Administration site: ☐ Thigh ☐ One nare ☐ Other _____

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

High Blood Sugar (Hyperglycemia) Treatment:

Student's usual symptoms of high blood sugar (list below): _____

_____

Treatment of high blood sugars: For blood sugars > 240mg/dl check urine/blood for ketones. If urine ketones are present, push sugar-free fluids and call parents or guardian. Continue to check for ketones every time he/she uses the bathroom.

Additional Treatment: _____

_____

Insulin Therapy:

Name of student's Insulin: _____

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

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 ratio = _____ units of insulin

Correction Factor: 1 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. *Add answer (units of insulin) to answer from insulin to carbohydrate ratio and*
4. *Round as appropriate.*

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

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

Correction Factor: 1 unit for every _____ mg/dl of blood sugar over _____ mg/dl.

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

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

Correction Factor: 1 unit for every _____ mg/dl of blood sugar over _____ mg/dl.

Can student give own insulin injections?	☐ Yes	☐ Yes, with adult supervision	☐ No
Can student determine correct amount of insulin?	☐ Yes	☐ Yes, with adult verification	☐ No
Can student draw up correct dose of insulin?	☐ Yes	☐ Yes, with adult supervision	☐ 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 ☐ Yes, with adult verification ☐ 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.

Other instructions: _____

Supplies at School:

- ☐ Blood glucose meter, blood glucose test strips, batteries for meter
- ☐ Lancet device and lancets
- ☐ Urine ketone strips
- ☐ Blood ketone meter and blood ketone strips
- ☐ Insulin vial and syringes
- ☐ Insulin pen and pen needles
- ☐ Fact-acting source of glucose
- ☐ Carbohydrate containing snacks
- ☐ Glucagon or Baqsimi emergency kit
- ☐ Other supplies: _____

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