Type 1 Action Foundation, Inc.

Diabetes Medical Management Plan

Student's Name _____

_____	_____	Type 1 Diabetes
Date of Birth	Grade	Disability

Date of Diagnosis _____

Date of Plan _____

School _____

School Phone _____

School Year _____ - _____

Homeroom Teacher _____

School Nurse _____

School Nurse Phone _____

Emergency Contact Information

Mother / Guardian _____

Address _____

Phone _____

Email _____

Father / Guardian _____

Address _____

Phone _____

Email _____

Name of Physician _____

Address _____

Phone _____

Email _____

Other Emergency Contact _____

Relationship _____

Address _____

Phone _____

Email _____

Other Emergency Contact _____

Relationship _____

Address _____

Phone _____

Email _____

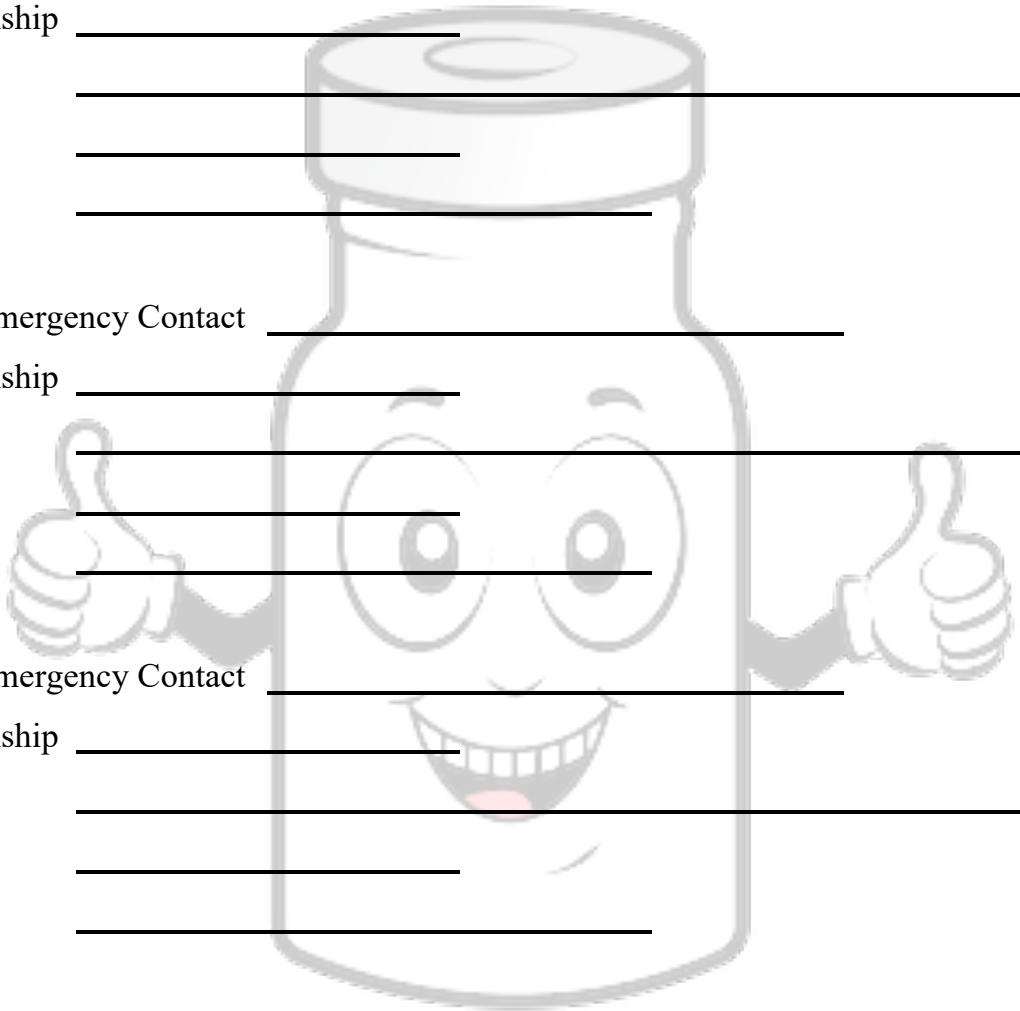
Other Emergency Contact _____

Relationship _____

Address _____

Phone _____

Email _____



Blood Glucose Testing

Target range of blood glucose: _____mg/dL

Check blood glucose level: ☐ Before lunch ☐ _____ Hours after lunch

☐ 2 hours after a correction dose ☐ Mid-morning ☐ Before PE ☐ After PE

☐ Before dismissal ☐ Other: _____

☐ As needed for signs/symptoms of low or high blood glucose

☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Fingertip ☐ Forearm ☐ Thigh ☐ Other: _____

Brand/Model of blood glucose meter: _____

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires school nurse or trained diabetes personnel to check blood glucose

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No

Brand/Model: _____

Alarms set for: ☐(low) and ☐(high)

Hypoglycemia Treatment

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

_____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 10-15 minutes and repeat treatment if blood glucose level is less than ____mg/dL.

Additional treatment: _____

_____

Hypoglycemia Treatment (Continued)

Follow physical activity and sports orders (see page 9).

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions, give:
- Glucagon: ☐ 1 mg ☐ 1/2 mg
  - Site for glucagon injection: ☐ arm ☐ thigh ☐ Other: _____
- Call 911 (Emergency Medical Services) and the student's parents/guardian.
- Contact student's physician.

Hyperglycemia Treatment

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

_____

_____

Check urine for ketones every _____ hours when blood glucose levels are above _____mg/dL.

For blood glucose levels greater than _____mg/dL and at least _____ hours since last insulin dose, give correction dose of insulin *(see below)*.

For insulin pump users: see additional information for student with insulin pump.

Give extra water and/or non-sugar-containing drinks (not fruit juices):_____ ounces per hour.

Additional treatment for ketones

Follow physical activity and sports orders (see page 9).

Notify parents/guardian of onset of hyperglycemia.

- If the student has symptoms of a hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911 and the student's parents/guardian.
- Contact student's physician

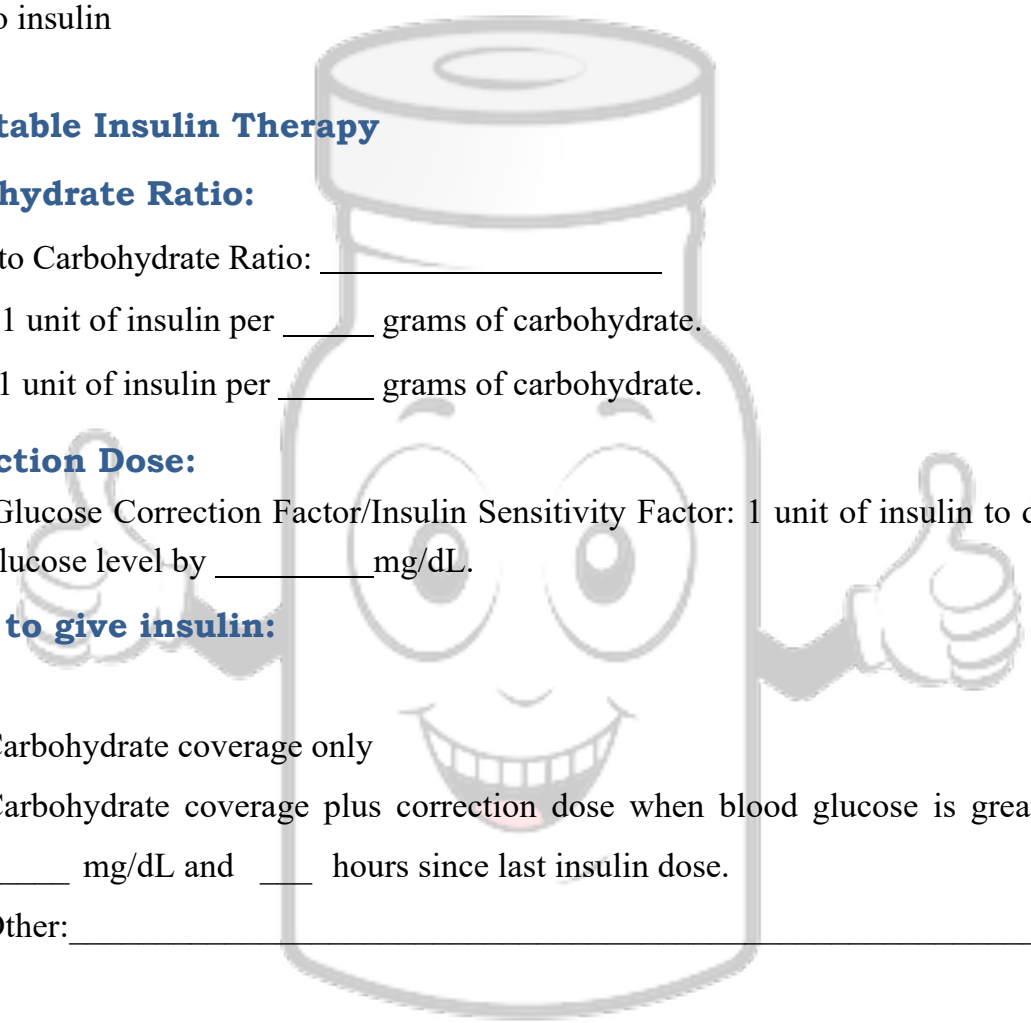
Insulin Therapy

Name of insulin: _____

Insulin delivery method: ☐ syringe ☐ insulin pen ☐ insulin pump

Type of insulin therapy at school:

☐ Adjustable Insulin Therapy
☐ Fixed Insulin Therapy
☐ No insulin



Adjustable Insulin Therapy

Carbohydrate Ratio:

Insulin to Carbohydrate Ratio: _____

Lunch: 1 unit of insulin per _____ grams of carbohydrate.

Snack: 1 unit of insulin per _____ grams of carbohydrate.

Correction Dose:

Blood Glucose Correction Factor/Insulin Sensitivity Factor: 1 unit of insulin to decrease blood glucose level by _____mg/dL.

When to give insulin:

Lunch

☐ Carbohydrate coverage only
☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and ___ hours since last insulin dose.
☐ Other:_____

Snack

☐ No coverage for snack
☐ Carbohydrate coverage only
☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and ___ hours since last insulin dose.
☐ Correction dose only *(continued on next page)*:

- For blood glucose greater than _____mg/dL and at least _____ hours since last insulin dose.

☐ Other:_____

Fixed Insulin Therapy

Name(s) of insulin: _____

☐ ____ units of insulin given pre-lunch daily.

☐ ____ units of insulin given pre-snack daily.

☐ Other:_____

Parental Authorization to Adjust Insulin Therapy Dosages:

☐ Yes ☐ No Parents/guardian authorization should be obtained before administering a correction dose.

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease insulin to carbohydrate ratio within the following range: _____ units of insulin per +/- _____ grams of carbohydrate.

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- ____ units of insulin.

Student's self-care insulin administration skill

☐ Yes ☐ No Independently calculates and gives own insulin injections.

☐ Yes ☐ No May calculate and give own insulin injections with supervision.

☐ Yes ☐ No Requires school nurse or trained diabetes personnel to calculate and give insulin injections.

Insulin Pump Therapy

Brand/Model of pump: _____

Basal rates during school: _____ units of insulin per hour.

Type of infusion set: _____

- ☐ For blood glucose greater than ____ mg/dL that has not decreased within hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.
- ☐ For infusion site failure: Insert new infusion set and/or replace reservoir.
- ☐ For suspected pump failure: suspend or remove pump and give insulin by syringe or pen.

Physical Activity with Insulin Pump Therapy

May disconnect from pump for sports activities ☐ Yes ☐ No

Set a temporary basal rate ☐ Yes ☐ No_____% temporary basal for _____ hours

Suspend pump use ☐ Yes ☐ No

Student's self-care pump skills:	Independent?
Count carbohydrates	☐ Yes ☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes ☐ No
Calculate and administer correction bolus	☐ Yes ☐ No
Calculate and set basal profiles	☐ Yes ☐ No
Calculate and set temporary basal rate	☐ Yes ☐ No
Change batteries	☐ Yes ☐ No
Disconnect pump	☐ Yes ☐ No
Reconnect pump to infusion set	☐ Yes ☐ No
Prepare reservoir and tubing	☐ Yes ☐ No
Insert infusion set	☐ Yes ☐ No
Troubleshoot alarms and malfunctions	☐ Yes ☐ No

Other Diabetes Medications

Name: _____ Dose: _____ Times given: _____

Name: _____ Dose: _____ Times given: _____

Name: _____ Dose: _____ Times given: _____

Meal Plan

Meal	Time	Carbohydrate Total
Breakfast	_____	_____
Morning Snack	_____	_____
Lunch	_____	_____
Afternoon Snack	_____	_____
Other	_____	_____
Other	_____	_____

Instructions for when food is provided to the class (e.g., as part of a class party or similar type of event): _____

_____

Special event/party food permitted: ☐ Parents/guardian discretion

☐ Student's discretion

Student's self-care nutrition skills:

☐ Independently counts carbohydrates

☐ May count carbohydrates with supervision

☐ Requires school nurse/trained diabetes personnel to count carbohydrates

Physical Activity and Sports

A quick-acting source of glucose such as ☐ glucose tabs and/or ☐ sugar-

containing juice must be available at the site of physical education activities and sports at all times.

☐ Student should eat _____ grams of carbohydrate ☐ before ☐ every 30 minutes during ☐ after vigorous physical activity

☐ If most recent blood glucose is less than _____ mg/dL, student may only participate in physical activity when blood glucose is corrected and above _____mg/dL.

☐ Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

☐ Additional information for student on insulin pump is in the insulin section on page 7

Disaster Plan

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.

☐ Continue to follow orders contained in this Diabetes Medical Management Plan.

☐ Additional insulin orders as follows: _____

☐ Other: _____

Signatures

This plan shall be reviewed with relevant school staff and copies shall be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

I, (parent/guardian:) _____ hereby consent permission to the school nurse, or other qualified health care professional or trained diabetes personnel of (school:) _____ to perform and carry out the diabetes

care procedures outlined herein (student:) _____'s Diabetes Medical Management Plan. I further 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 the information contained herein for the purpose of maintaining my child's health and safety. Lastly, I consent permission to the school nurse or other qualified health care professional to contact my child's physician as needed, the number for which is located on page 2 of this Diabetes Medical Management Plan.

This Diabetes Medical Management Plan has been approved by:

Student's Physician (print)	Student's Physician (sign)	Date

WHEREFORE, this Diabetes Medical Management Plan is hereby acknowledged and received as of this date of _____.

Parent/Guardian (print)	Parent/Guardian (sign)	Date
Parent/Guardian (print)	Parent/Guardian (sign)	Date
School Nurse (print)	School Nurse (sign)	Date