SCHOOL DISTRICT OF WASHINGTON
HEALTH SERVICES

Date of Plan: _____ **Student Picture**

Diabetes Medical Management Plan

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, trained diabetes personnel, and other authorized personnel.

Effective Dates: _____

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ School: _____ Homeroom Teacher: _____

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

Contact Information

Mother/Guardian: _____ Address: _____

Telephone: Home _____ Work _____ Cell_____

Father/Guardian: _____ Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/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: _____

_____

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

Insulin
Usual Lunchtime Dose
Base dose 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
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl

Parents are authorized **(with Physician/Health Care Provider signature)** to adjust the insulin dosage under the following circumstances:

_____

_____

If blood glucose is over 500 and insulin has been given per correction dose parents will be notified to pickup the student for closer monitoring.

For Students with Insulin Pumps
Type of pump: _____ Basal rates: _____ 12 am to _____
_____ _____ to _____
_____ _____ to _____
Type of insulin in pump: _____Type of infusion set: _____
Insulin/carbohydrate ratio: _____ Correction factor: _____

Meals and Snacks Eaten at School
Is insulin needed with snacks? ☐ Yes ☐ No _____

Meal/Snack	*Amount of Carbs*		*Amount of Carbs*
Mid-morning snack	_____	Snack before exercise? ☐ Yes ☐ No	_____
Lunch	_____	Snack after exercise? ☐ Yes ☐ No	_____
Mid-afternoon snack	_____		

Other times to give snacks and content/amount: _____
_____

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

_____

_____

Exercise and Sports
It is the parent/guardian's responsibility to ensure that all needed diabetic supplies and snacks are available to the student during any extra curricular activity or after school sport. Nurses are not available before or after school hours and their offices are not accessible.
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)
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 glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)
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, alcohol wipes, etc.
_____Urine ketone strips
_____Insulin pump and supplies
_____Insulin pen, pen needles, insulin cartridges
_____Fast-acting source of glucose
_____Carbohydrate containing snack
_____Glucagon emergency kit

Self Carry and Administration of Medication
This student will be allowed to carry the medications and supplies listed in this care plan on his/her person or to keep these medications in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of the use of these medications and supplies. If he/she feels the need to use the medications or supplies, he/she may use them and then report to the school nurse or office so that the use of these medications and supplies may be recorded and monitored. He/she will be required to demonstrate proper self-administration technique to the school nurse at the beginning of the year and as she deems necessary.

Special Meals
I certify that the above named student needs special school meals (requiring omitted/substitutions) due to the student's medical condition.

Physician Agreement? ☐ Yes ☐ No

This Diabetes Medical Management Plan has been approved by:

_____ _____
Physician/Health Care Provider Signature Date

The Washington School District shall incur no liability as a result of any injury arising from the student's self management and administration of the medications and procedures listed in this care plan, and the parents/guardians shall indemnify and hold harmless the district and it's employees or agents against any claims arising out of the student's self management and administration of medications and procedures. We, the undersigned, absolve the Washington School District of any responsibility in safeguarding our child's medication.

Parent Agreement? ☐ Yes ☐ No

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of **SCHOOL DISTRICT OF WASHINGTON** to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members, First Student Transportation Company, 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:

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

Received in Nurses Office on: _____