WESTERN LINE SCHOOL DISTRICT

"Committed to Excellence in Education"

Date of Plan:

Western Line School District Health Services
Diabetes Medical Management Plan

School Year: ________________________________ Grade: ________________________

Student's Name: ________________________________ Date of Birth: ____________________

Date of Diabetes Diagnosis: _______________ Homeroom Teacher: _________

Physical Condition: ____

Contact Information

Mother/Guardian: ____

Address: ____

Telephone: Home ____________________ Work ___________________ Cell _________________

Student's Doctor/Health Care Provider:____

Address: ____

Telephone: _____________________Emergency Number: _________________________________

Other Emergency Contacts: Name: ____

Relationship: ____

Telephone: Cell ______________________________________

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

____
____
____

Blood Glucose Monitoring

Target range for blood glucose is **80-150**

Usual times to check blood glucose ____

Times to do extra blood glucose checks:

*when student exhibits symptoms of hyperglycemia

*when student exhibits symptoms of hypoglycemia

other (explain): ____

Can student perform own blood glucose checks? _____Yes ___No

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Exceptions: ____

____

Type of blood glucose meter student uses: -_______________________________________

Insulin:____

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

Can student give own injections? _______Yes _______No

Can student determine correct amount of insulin? _______Yes _______No

Can student draw correct dose of insulin? _______

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

____

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

Meal/Snack Time Food content/amount

Breakfast ____

Mid-morning snack ____

Lunch ____

Mid-afternoon snack ____

Dinner ____

Other times to give snacks and content/amount:

Preferred snack foods: ____

Foods to avoid, if any: ____

Exercise and Sports

A fast-acting carbohydrate such as ____________________________ should be available at the site of exercise or sports.

Restrictions on activity, if any: ______________________________ 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.

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)

Usual symptoms of hyperglycemia: ____

____

Treatment of Hyperglycemia:____

____

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

Treatment for ketones: ____

____

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Supplies to be kept at School

_____ Blood glucose meter, blood glucose test strips, batteries for meter

_____ Lancet device, lancets, gloves, etc.

_____ Urine ketone strips

_____ 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 of the Western Line School District 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 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

____ ____________________

School Nurse Date