Four County Career Center

Diabetes Medical Management Plan

Student Name:____ Date of Birth:_____________________

Age of Diabetes diagnosis:____________ Type of Diabetes: Type I ________ Type II_____________

Lab Program:__________________________________ School Year:___________________ Grade level:___________

Teachers____

Physician Name:

Address:

Telephone number:

Parent(s) name(s):____

Telephone numbers #1_____________________ #2__________________ #3_______________

Students taking oral diabetes medication:

Type of medication___________________________ Dosage___________ Time given:________________

Other Medication(s):_________________________ Dosage____________ Time given:________________

Insulin Delivery

Method of insulin delivery at school: ______syringe _______Insulin pen ______Insulin pump

Medication: To be kept with student_________ To be kept in Nurse office________________

Check one: Student is independent will insulin calculations/delivery______________

Student needs assistance with insulin calculations/ delivery___________

Insulin Correction Doses

Type of insulin:________________________________

Glucose level (mg/dl)	Units of Insulin
Less than 100	
101-150	
151-200	
201-250	
251-300	
301-350	
351-400	
401-450	
451-500	

Meal Bolus: Insulin-carbohydrate ratio_________ unit(s) of insulin for every_________ grams of carbohydrates (CHO)

CHO eaten (or will eat)	Units of Insulin

Target range for blood glucose:___________________

Hypoglycemia

Symptoms: shaky, feels low, feels hungry, confused, other________________________________

- Student needs treatment when blood sugar is below___________ mg/dl or is symptomatic
- Recheck blood glucose after 15 minutes
- Glucagon should be given when student is unable to swallow, is unconscious, or having a seizure. If glucagon is administered, call 911. Route of administration_____Dosage________ site for injection_______________.

Hyperglycemia

Symptoms: thirst, increase need for urination, irritability, other___________________________

- Student needs treatment when blood glucose is over__________ mg/dl
- Urine should be checked for ketones when blood glucose levels are above_____________mg/dl.
- **If blood sugar is over ___________ mg/dl contact parent**

Blood Glucose Testing

Student is independent_________ Student needs assistance and supervision with testing__________

Times to test:

____ before lunch _____before going home _______ as needed ______other_____________

Additional Information:

- Student must always be allowed access to fast acting sugar.
- Student is allowed to carry a water bottle and have unrestricted bathroom privileges.
- Student is allowed to test blood glucose when and where needed.
- Student will be accompanied by a responsible person to nurse office when student has symptoms of hypoglycemia or hyperglycemia.

Insulin Pumps

Type of Pump:______________________________ Type of insulin in pump_________________________

Basal rates: ___________12 AM to ____________ ; other ____ _____to ______ ; ______ ______ to _______

Other information:

Diabetes Care Supplies

It is the student/ parent responsibility to ensure the student has the following supplies at school: (check all that apply)

_____Blood glucose meter, test strips and extra batteries for meter

_____Lancet devices ____Ketone strips _____insulin delivery devices(pumps, pens, needle/ syringe,)

_____Fast acting source of glucose _____Snacks _____Glucagon Emergency Kit ______water bottle

_____Other_________________________________

I give permission to the school nurse, trained diabetes personnel, and other designated employees of Four County Career Center to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all employees who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I authorize the sharing of medical information about my child, ________________, between my child's physician and other health care providers in the school.

____ _________________________

Parent/ Guardian Signature Date

This diabetes medical management plan has been approved by:

____ _______________________

Physician Signature Date

____ ______________________

School Nurse Signature Date