Needham Public Schools

Diabetes Medical Management Plan

This plan should be completed by the student's personal health care team and parent(s)/guardian(s). It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse and other authorized personnel.

Date of Plan: _____

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Teacher/Advisor:_____

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

Contact Information

1) Parent/Guardian: _____

Address: _____

Telephone: Cell _____ Work _____ Home_____

2) Parent/Guardian: _____

Address: _____

Telephone: Cell _____ Work _____ Home _____

Other Emergency Contacts:

Name: _____

Address: _____

Telephone: Cell_____ Work _____ Home _____

Student's Endocrinologist:

Name: _____

Clinic/Hospital Name and Location:_____

Telephone: _____ Emergency Number: _____

Student's Diabetes Nurse Educator:

Name: _____

Clinic/Hospital Name and Location: _____

Telephone: _____ Emergency Number: _____

Blood Glucose Monitoring

Target range for blood glucose pre meals:_____

Before meals/snacks monitoring: Glucometer_____ or CGM_____

Additional blood glucose checks (PE, recess, end of day etc.)_____

Type of blood glucose meter student uses: _____

Continuous Glucose Monitoring (CGM) YES_____ NO_____

Brand/Model_____

CGM approved for bolus dosing YES___ NO___

Alarms parameters: Urgent Low:_____ Low:_____ High:_____

Predictive alarm: Low:_____ High:_____ N/A_____

Rate of change: Fall:_____ Rise_____ N/A_____

Threshold suspend setting:_____ N/A_____

Calibration required: YES_____ N/A_____

Other instructions:_____

If the student's CGM is shared via an app to a device in the school nurse's office please be aware that the nurse cannot monitor the device constantly when tending to other students or when called to another location.

Notify parent/guardian or emergency contact in the following situations: _____

_____

_____

Insulin Administration by Injection

Insulin Orders attached to form: YES_____ or see below:_____

Insulin/Carbohydrate Ratio:_____

Correction/Sensitivity Factor_____

Target Blood Glucose_____

High Blood Glucose Correction Formula_____or Sliding Scale Correction_____

Parental authorization should be obtained before administering a correction dose for high blood glucose levels. Yes_____ No_____

Insulin Correction Formula:

Insulin Correction Doses/Sliding Scale Insulin

_____ 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

Parents are authorized to adjust the insulin dosage by _____% via injection or pump

Insulin Administration by Pump

Type of pump: _____

Type of infusion set if needed: _____

Insulin used in pump_____ Orders attached_____or see below:

Usual Basal rates: _____12 am to _____

_____ _____ to _____

_____ _____ to _____

_____ _____ to _____

Additional Programmed Basal Profiles: N/A_____ YES(attach all profiles)_____

Insulin/carbohydrate ratio: _____ Correction/Sensitivity factor: _____

Pump functions as Hybrid Closed Loop: N/A_____ via pump_____or link/app_____

Food in the Classroom

Instructions for when food is provided (e.g., as part of curriculum or food sampling event):

_____

_____

Physical Education, Sports and Exercise

A fast-acting carbohydrate should be available at the site of physical education, exercise, or sports _____ or carried by student_____

Restrictions on activity: CGM/Blood Glucose value

below_____mg/dl above_____mg/dl without ketones present

above_____ mg/dl with ketones 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. If **Glucagon** is administered, 9-1-1 will be called and the parents/guardian notified. Medication order attached_____ or see below:

Route: IM_____ SC_____ Nasal_____ Dosage _____

Site for Glucagon ordered by injection: _____

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: _____

_____

Additional individual information pertinent to diabetes management during the school day for _____:

Required signatures on next page

Form will not be accepted without appropriate signatures

This Diabetes Medical Management Plan has been approved by:

_____ _____

Student's Physician/Health Care Provider **Date**

I, the undersigned parent or guardian, give permission to the school nurse to administer the above medication(s) to my child, or to supervise my child in taking the above medication as approved by the school nurse.

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.

_____ _____

Student's Parent/Guardian **Date**

Acknowledged and received by:

_____ _____

School Nurse **Date**

Diabetes Plan of Care for the current school year will be completed in collaboration with parent/guardian, school nurse and student based on provider orders and above forms prior to start of school or before return to school after a new diagnosis

Updated 06/2020
Adapted from American Diabetes Association Diabetes Medical Management Form