VICTORIA INDEPENDENT SCHOOL DISTRICT
Diabetes Medical Management Plan

This plan should be completed by the student's personal health care team and parents/guardian.

Student's Name:_____
Date of Birth:_____ Date of Diabetes Diagnosis:_____
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: _____
Hospital Preference: _____ Telephone: _____
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: _____
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 carry blood glucose testing materials and perform own blood glucose checks? □ Yes □ No
Exceptions: _____

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Insulin

Usual Lunchtime Dose

Base dose of Humalog/Novalog/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

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
Can student give own injections? □ Yes □ No
Can student determine correct amount of insulin? □ Yes □ No
_____ Parents are authorized to adjust insulin dosage under the following circumstances: _____

For Students With Insulin Pumps

Type of pump _____Basal rates:_____12a.m. to _____
_____ ____ to _____
_____ _____ to _____
Type of insulin in pump: _____
Type of infusion set: _____
Insulin/carbohydrate ratio: _____Correction factor: _____
Protocol for pump failure:
_____
_____
_____

Student Pump Abilities/Skills	*Needs Assistance*	
Count carbohydrates	□ Yes	□ No
Bolus correct amount for carbohydrates consumed	□ Yes	□ No
Calculate and administer corrective bolus	□ Yes	□ No
Calculate and set basal profiles	□ Yes	□ No
Calculate and set temporary basal rate	□ Yes	□ No
Disconnect pump	□ Yes	□ No
Reconnect pump at infusion set	□ Yes	□ No
Prepare reservoir and tubing	□ Yes	□ No
Insert infusion set	□ Yes	□ No
Troubleshoot alarms and malfunctions	□ Yes	□ No

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	_____	_____
Snack before exercise	□ Yes □ No	
Snack after exercise	□ Yes □ No	

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

Exercise and Sports
A fast-acting carbohydrate such as _____should be available at the site of exercise or sports.
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)
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 glucagons 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: _____
_____
Check urine 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
_____Insulin vials and syringes
_____Insulin pump and supplies
_____Insulin pen, pen needles, cartridges
_____Fast-acting source of glucose
_____Carbohydrate containing snack
_____Glucagon emergency kit

This Diabetes Medical Management Plan has been approved by:

_____ _____
Student's Physician/Health Care Provider Date

Parent/Guardian/Student Signatures (Please initial all that apply)

_____I give permission to the campus nurse or a trained unlicensed diabetes care assistant to assist or administer diabetes care to my child in compliance with *Section 1, Subtitle H, Title 2, Health and Safety Code.* I understand that this care will be given in accordance with my child's Individualized Health Care Plan in compliance with the guidelines provided during training under *Section 168.005.* I understand that an unlicensed diabetes care assistant is not liable for civil damages as provided by
Section 168.009.

_____Information concerning my child's diabetes management may be shared with/obtained from the diabetes health care provider and shared with staff involved in the care of my child to maintain health and safety.

_____I understand that supplies, including snacks, are to be provided by the parent/guardian.

_____ I authorize my child to carry his/her own diabetes testing materials and self-test. Any results outside of target range will be reported to school nurse.

Acknowledged and received by:

_____ _____
Student's Parent/Guardian Date

_____ _____
Student's Parent/Guardian Date

_____ _____
Student Date

_____ _____
School Nurse Date