Scotus Central Catholic High School

1554 18th Ave., Columbus, NE, 68601; 402-564-7165; FAX 402-564-6004

www.scotuscc.org

Diabetes Medical Management Plan

Date of Plan: _____ Effective Dates: _____

Student Name: _____

Date of Birth: _____ Current Grade Level: _____

Date of Diagnosis: _____ Condition: ☐ Diabetes Type 1 ☐ Diabetes Type 2

Contact Information:

Mother/Guardian: _____

Address: _____

Phone: (Home) _____(Work)_____(Cell)_____

E-mail: _____

Father/Guardian: _____

Address: _____

Phone: (Home) _____(Work)_____(Cell)_____

E-mail: _____

Doctor/Health Care Provider: _____

Address: _____

Phone: _____

Emergency Contact and relationship: _____

Address: _____

Phone: (Home) _____(Work)_____(Cell)_____

E-mail: _____

Parent/Guardian/Emergency Contact is to be contacted in the following situation(s): _____

_____

_____

_____

_____

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

Exceptions: _____

Type of blood glucose meter student uses: _____

Insulin:

Usual Lunchtime Dose:

Base dose of (please circle one) Humalog/Novolog/Regular Insulin (please circle one) used at lunch is _____ units or flexible dosing using _____ units /_____ grams of carbohydrates.

Use of other insulin at lunch (please circle one): Intermediate/NPH/Lente _____ units or Basal/Lantus/ Ultralente _____ units.

Insulin Correction Doses:

Parental authorization to administer a corrections 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? ☐ Yes ☐ No

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

_____

_____

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: _____

Student Pump Abilities/Skills:	***Needs Assistance (please circle):***	
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 Medications:

Type of medication: _____ Timing: _____

Other medication: _____ Timing: _____

Meals and Snacks Eaten at School:

Is the student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Meal/Snack:	*Time:*	*Food Content/Amount:*
Breakfast	_____	_____
Mid-morning snack	_____	_____

Meal/Snack:	*Time:*	*Food Content/Amount:*
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

Snack before exercise? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount: _____

Preferred snack foods: _____

Foods to avoid, if any: _____

Instructions for when food is provided to the class (such as a class party or food sampling event): _____

_____

_____

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 is 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 injection ☐ Arm ☐ Thigh ☐ Other _____

<u>NOTE: If glucagon is required, administer it promptly; call 911 or other emergency assistance and the parent/guardian or emergency medical contact, if necessary.</u>

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: _____

Supplies to be kept at school:

_____Blood glucose meter/test strips/batteries
_____Lancet device/lancets/gloves
_____Insulin vials and syringes
_____Fast-acting source of glucose
_____Glucagon emergency kit
_____Insulin pen/pen needles/insulin cartridges
_____Urine ketone strips
_____Insulin pump/supplies
_____Carbohydrate-containing snack

Physician/Health Care Provider Signature:

I, _____, approve this diabetes medical management plan on this _____ day of _____, 20_____.

Parent/Guardian Signature(s):

I, _____, give permission to the school nurse, trained diabetes personnel and other designated staff members of Scotus Central Catholic Junior/Senior High School to perform and carry out the diabetes care tasks as outlined in the diabetes medical management plan for (student's name) _____. I also consent to the release of the information contained in the diabetes medical management plan to all staff members and other adults who has 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 printed name: _____

Parent/Guardian signature: _____ Date:_____

Parent/Guardian printed name: _____

Parent/Guardian signature: _____ Date:_____

RELEASE AND INDEMNIFICATION AGREEMENT
(Self-Administration of Diabetic Condition)

I,_____ hereby acknowledge that Scotus Central Catholic, including its employees and agents (School) is not liable for any injury or death arising out of the self-management by _____ of his/her diabetic condition and I hereby indemnify and hold School from any claim arising from the student's self-management. In the event that _____ injures school personnel or another student as a result of misuse of the prescription diabetes medication or related medical supplies, the undersigned shall be responsible for any and all costs associated with the injury.

_____ _____

Date Parent or Guardian