

Diabetes Medical Management Plan

Cape May County Technical School

This plan should be completed by the parent/guardian and reviewed by your child's Diabetes Management Physician or Nurse practitioner.

Parent/Guardian: If you do not supply the annually updated medical plan, your child will not be permitted to participate in sports or any off campus activity, including field trips.

Student's Name

(Print): _____ Date of Birth: ___/___/___ Grade: _____ Full or Half Day

Circle one: Diabetes type 1 Diabetes type 2 Year student was diagnosed: _____

Other conditions you would like school personnel to know of: _____

Contact Information

Parent/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Other Emergency Contacts:

Name: _____ Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Student's Primary Doctor/Health Care Provider: Name: _____

Office Location City/State: _____ Telephone: _____

Student's Diabetes Physician or Diabetes Team: Name: _____

Office Location City/State: _____ Telephone: _____

HYPOGLYCEMIA (Low Blood Sugar): What are your child's typical signs or behaviors?

HYPERGLYCEMIA (High Blood Sugar): What are your child's typical signs or behaviors?

Blood Glucose Monitoring: Is your child able to perform own blood glucose testing? Yes No

Type of blood glucose meter used: _____

Times to do blood glucose checks (*check all that apply*):

- Pre-meal times (circle): breakfast lunch dinner Prior to bedtime Before exercise After exercise
- Hyperglycemia symptoms Hypoglycemia symptoms Prior to driving or operating hazardous machinery
- Other (explain): _____

For Students Taking Oral Diabetes Medications:

Name of medication: _____ Dose: _____ Times taken: _____

Are modifications to your child's educational program needed? NO YES

If "YES", parent/guardian please contact the school's 504 Plan Coordinator or Guidance Counselor.

For Students on Insulin Pump: Pump Type: _____ Type of insulin: _____

Basal rates: _____ 12 am to _____ Basal rates _____ to _____ Basal rates _____ to _____

Type of infusion set: _____

Student Pump Abilities/Skills: Student is knowledgeable to:

Count carbohydrates? Yes No Bolus amount for carbohydrates consumed? Yes No

Calculate and administer corrective bolus? Yes No Troubleshoot alarms and malfunctions? 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

INSULIN PRESCRIBED VIA INSULIN PEN OR SYRINGE:

MORNING Insulin(s): Type: _____ Dose: _____

Type: _____ Dose: _____

LUNCHTIME Insulin(s): Type: _____ Dose: _____

Type: _____ Dose: _____

DINNERTIME Insulin(s): Type: _____ Dose: _____

Type: _____ Dose: _____

EVENING/NIGHT TIME Insulin: Type: _____ Dose: _____

Meals and Snacks Eaten at School:

Is student independent in carbohydrate calculations and management? Yes No

Daily Meal/Snack Food number of carbohydrates prescribed:

Breakfast carbohydrate: _____ gm Mid-morning snack carbohydrate: _____ gm

Lunch carbohydrate: _____ gm Mid-afternoon snack carbohydrate: _____ gm

Dinner carbohydrate: _____ gm Bedtime snack carbohydrate: _____ gm

Snack before exercise? Yes No Snack after exercise? Yes No Estimate snack carbohydrates: _____ gm

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

The following supplies are to be provided by parent/guardian:

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

_____ Lancet device, lancets, gloves, container for sharps disposal, etc.

_____ Urine ketone strips

_____ Insulin pump and supplies

_____ Insulin pen, pen needles, insulin cartridges

_____ Fast-acting source of glucose such as glucose tablets or glucose gel

_____ Carbohydrate containing snack(s) (Provide meal if staying after school.)

_____ Glucagon emergency kit for school nurse/delegate. (If child is in sport need one for team kit also.)

Note: If your child is sick and following "diabetic sick day rules" he/she should remain home until well.

Parent/guardian signature: _____ Date: ____/____/____

Child's Name : _____

D.O.B.: ____/____/____

DIABETES MANAGEMENT PLAN IN SCHOOL AGREEMENT AND RELEASE

PARENT/GUARDIAN COMPLETES: I give permission to the school nurse, trained diabetes personnel, and other designated staff members of Cape May County Technical School to perform, to carry out, and/or to assist in the Diabetes Medical Management Plan for my child as outline by me and my child's health care team.

I consent to the release of information contained in this plan to school staff or emergency care personnel who may need to know this information. I consent to the release of information between my child's Diabetes Management Team (the treating Physician, Nurse Practitioner or Diabetic Educator) and the School Nurse.

I understand that my child should wear a medical identification bracelet or necklace at all times. As the school nurse is not available for after school activities, sporting events, or field trips, I will inform adult staff that may be in charge of an after school event or field trip, that my child has diabetes and ensure my child has his/her supplies available to manage his/her care. *

Note: The school nurse does not routinely go on school field trips, sporting events, and is not available for after school events. For this reason a school employee will be trained by the school nurse as a delegate to administer Glucagon to your child if he/she demonstrates symptoms of hypoglycemia and is unconscious, unable to swallow, or having a seizure believed to be related to hypoglycemia. (Additionally, "911" will be initiated in all such circumstances). It is the parent/guardian's responsibility to provide the Glucagon injection kit to the school. There is no delegate on the school bus to/from school therefore Glucagon will not be able to be given should an event occur on the school bus. The school bus driver will call "911" in the event your child exhibits signs of hypoglycemia and can not swallow, is unconscious or having a seizure. It is the guardian's responsibility to supply a source of quick acting glucose to the bus driver in the event your child should need it (we suggest two tubes of 15gm glucose gel).

PRINT NAME: Parent/Guardian

Signature

____/____/____
Date

If your child is not independent with management of his/her diabetes please contact the building Principal and school nurse for accommodations for field trips and school sponsored events.

STUDENT AGREEMENT:

I agree to make every attempt to follow the diabetic management plan outlined by my diabetes management team. I will notify a staff member if I feel symptoms of low or high blood sugar.

I AGREE TO DISPOSE OF ANY SHARPS OR MATERIAL THAT MAY CONTAIN BLOOD IN A SAFE MANNER. I WILL NOT DISPOSE OF SUCH LOOSE ITEMS IN THE SCHOOL TRASH.

(STUDENT MAY USE OWN SEALED CONTAINER FOR DISPOSAL LATER AT HOME OR USE THE SHARPS DISPOSAL IN THE SCHOOL NURSE'S OFFICE). I AGREE TO CLEAN UP THE TESTING AREA THAT MAY BECOME CONTAMINATED WITH DROPS OF BLOOD USING SCHOOL APPROVED ANTISEPTIC CLEANING WIPES.

Student's Signature _____

Date: ____/____/____

Quick Reference Emergency Plan for a Student with Diabetes



Hypoglycemia (Low Blood Sugar)

Student's Name _____

Grade/Teacher _____ Date of Plan _____

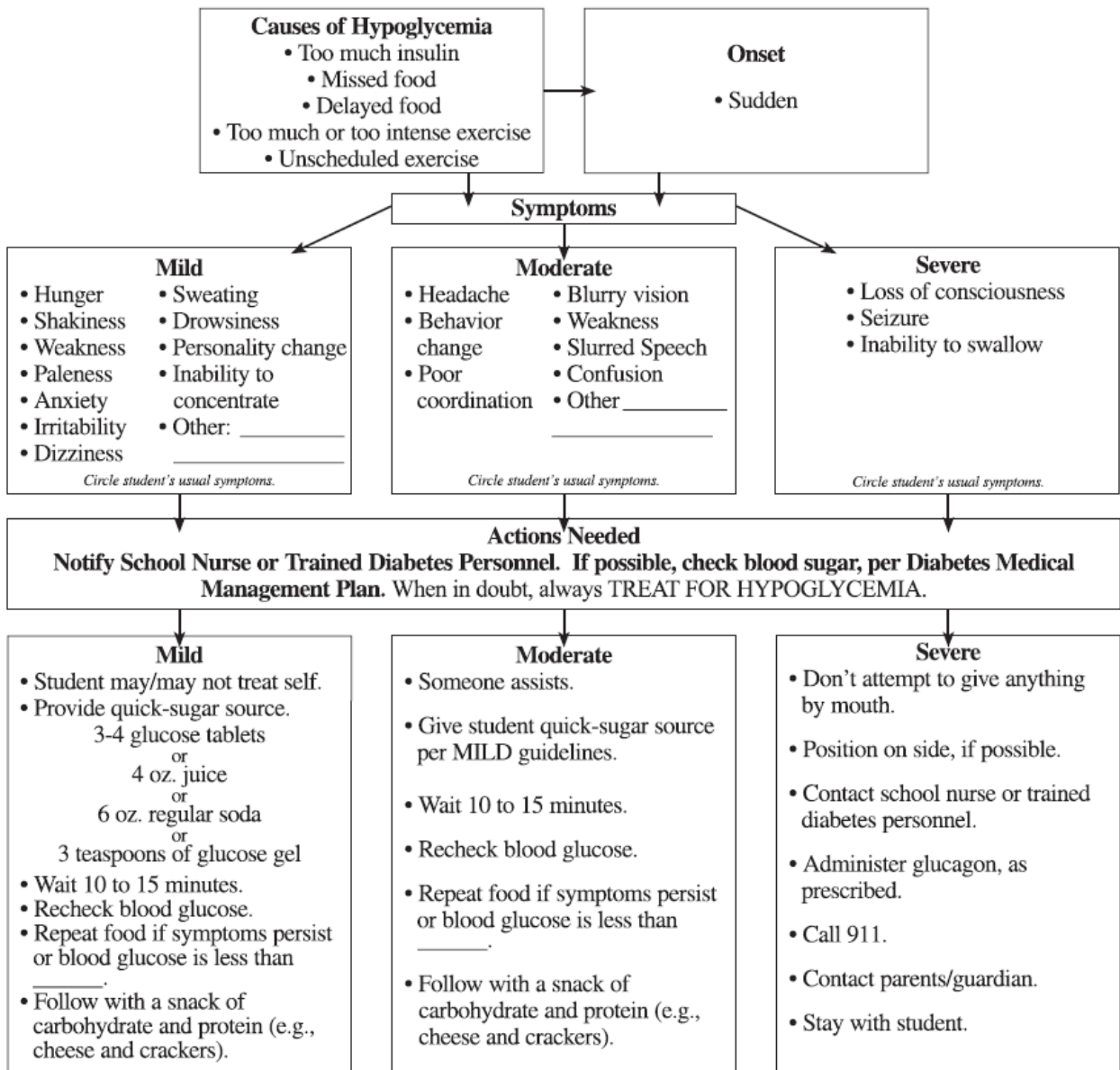
Emergency Contact Information: _____

Mother/Guardian _____ Father/Guardian _____

Home phone _____ Work phone _____ Cell _____ Home phone _____ Work phone _____ Cell _____

School Nurse/Trained Diabetes Personnel _____ Contact Number(s) _____

Never send a child with suspected low blood sugar anywhere alone.



The Quick Reference Emergency Plan can be found in NDEP's "Helping the Student with Diabetes Succeed: A Guide for School Personnel," which is available for free download at http://www.ndep.nih.gov/diabetes/pubs/youth_ndepschoolguide.pdf

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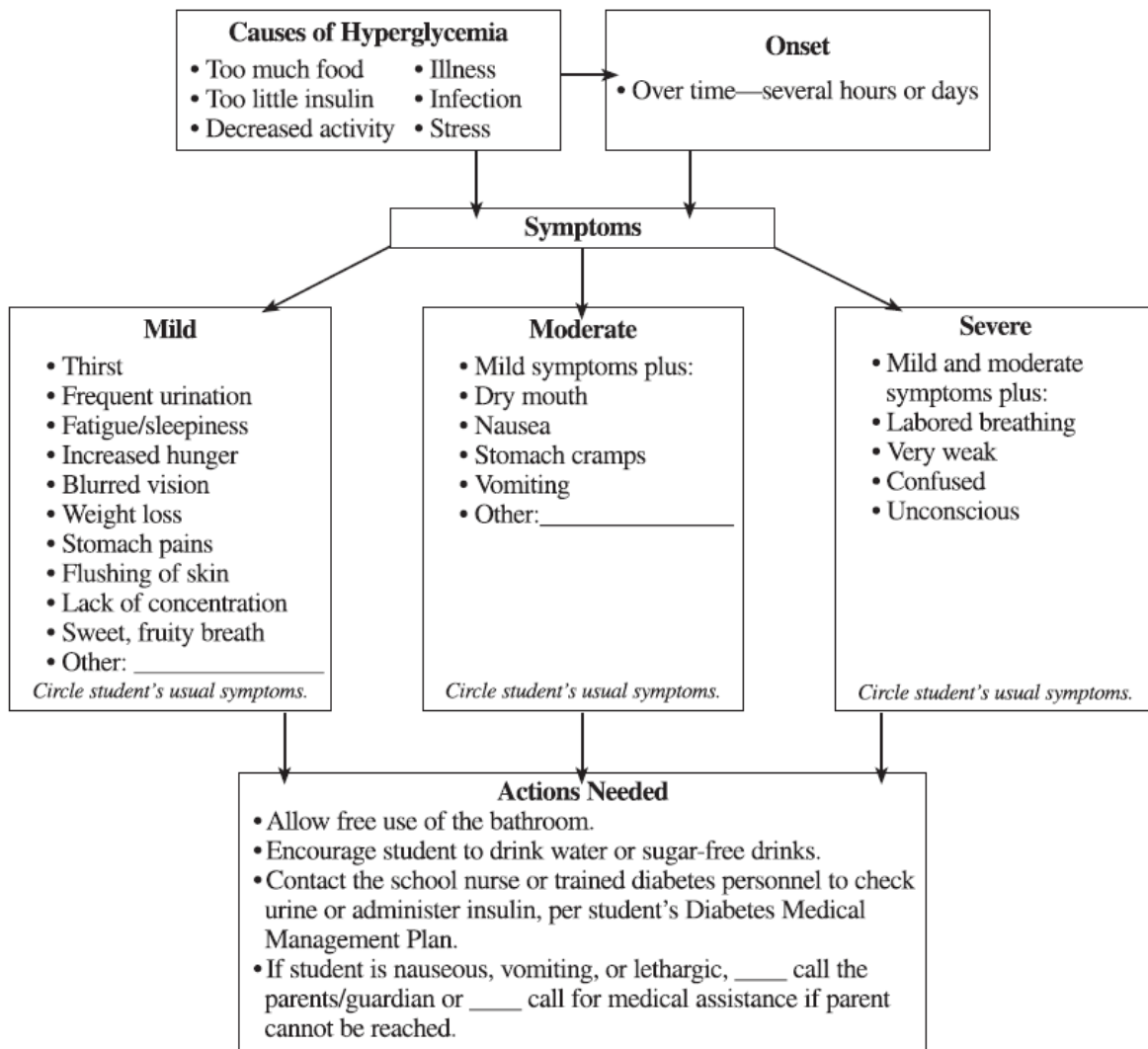
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