Alpine Academy of Rockford

Diabetes Medical Management Plan

Year: _____/_____

Name: _____ DOB: _____ Grade: _____

Address: _____ City: _____ Zip: _____ Phone: _____

Parent #1 _____ Parent #2 _____

Cell Phone: _____ Work Phone: _____ Cell Phone: _____ Work Phone: _____

Endocrinologist: _____ Phone: _____ Physician: _____ Phone: _____

Blood Glucose Monitoring

Target range for blood glucose: _____ mg/dl to _____mg/dl May the student perform his/her own glucose test? □ Yes □

Times to check blood glucose: (check all that apply) Skills verified by: _____ on _____

□ Before morning snack □ Before lunch □ Signs of hypoglycemia □ Signs of hyperglycemia

□ Before P.E Note: No P.E. if blood glucose is less than _____mg/dl or greater than _____mg/dl

□ Other; please explain_____

School Personnel trained to assist with and perform blood glucose monitoring:

1. _____ 2. _____ 3. _____

Hypoglycemia (low blood glucose)

List usual symptoms: _____

_____

Treatment:_____

_____

Glucagon: A Glucagon injection should be given if the student is unconscious, having a seizure, or is unable to swallow. If required, Glucagon should be given promptly then 911 and the parents should be called.

Hyperglycemia (high blood glucose)

List usual symptoms: _____

_____

Treatment:_____

_____

Parental notification for blood glucose greater than _____mg/dl

Ketone testing at school: □ Yes □ No

If yes, when:_____

Daily Routine (indicate day, time, and other information as necessary)

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning Snack					
Lunch					
Afternoon Snack					
P.E.					
Before/Aftercare					

Preferred snack foods: _____ Foods to avoid, if any: _____

Instructions for when food is provided to the class (example: birthday treats): _____

Other instructions: _____

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Insulin Injections

Type: _____ Time: _____
Insulin/carbohydrate ration for Lantus insulin: _____
Sliding Scale: □ Yes □No If yes, refer to the Authorization for Administration of Insulin form.

Can the student give his/her own injections? □Yes □No
Can the student determine the correct amount? □Yes □No
Can the student draw the correct amount? □Yes □No

Skills verified by: _____ on _____
Comments:_____

School personnel trained to assist with insulin administration:
1. _____ 3. _____
2. _____ 4. _____

Insulin Pump

Type of pump: _____ Basal rate: _____

Correction factor:_____

Insulin/carbohydrate ratio:_____

Is the student competent regarding the pump? □Yes □No

Skills verified by: _____ on _____

Can the student troubleshoot problems? □Yes □No

Skills verified by: _____ on _____
Comments:_____

Location of Supplies (check the appropriate boxes)

	With the student	In the classroom	Nurses office: Refrigerator	Nurses office: Med cabinet
Glucose Monitor				
Monitor supplies				
Insulin				
Insulin pen				
Syringes				
Pump supplies				
Ketone strips				
Glucagon				
Snacks				
Other:_____				

Authorization

The information contained on this document has been agreed upon and deemed accurate by the student, parents/guardians, teacher and registered nurse. This document will be reviewed on an annual basis and at anytime upon the request of the parent/guardians, teachers, or registered nurse.

Parent #1:_____ Patent #2:_____

Student:_____ Teacher:_____

Nurse:_____ Date:_____

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