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 li			_				
Contact Information							
Parent/Guardian:							
Address:					_		
Telephone: Home					_		
Other Emergency Contacts:							
Name:		Rel	lationship: _				
Telephone: Home	Work		_ Cell		_		
Student's Primary Doctor/Hea	alth Care Provider:	Name:					
Office Location	on City/State:		To	elephone:			
Student's Diabetes Physician	or Diabetes Team:	Name:					
	on City/State:						
Office Ecount	on engretate.			orephone			
HYPOGLYCEMIA (Low Blo	ood Sugar): What a	re your child's ty	pical signs o	or behaviors?			
HVDEDCI VCEMIA (III-II E	Ola ad Cararaha What			1			
HYPERGLYCEMIA (High E	siood Sugar): what	are your child s ty	ypicai signs	or benaviors?			
Blood Glucose Monitoring:	Is your child able to	perform own blo	ood glucose	testing? Yes N	No		
Type of blood glucose meter							
<u>Times</u> to do blood glucose ch	·		. 1	D. C.	□ A C		
☐ Pre-meal times (circle): br							
☐ Hyperglycemia symptoms☐ Other (explain):		symptoms Pi	ioi to urivili	ig or operating in	azardous macminery		
Union (explain).							
For Students Taking Oral D	Diabetes Medication	ns:					
Name of medication:		_ Dose:	_ Times tal	ken:			
Are modifications to your ch	nild's educational r	orogram needed?		YES			
If "YES", parent/guardian		•			ance 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/Skill	s: Studer	nt is knowledge	eable to:				
Count carbohydrates? Yes No			Bolus amount for	carbohydrates consume	ed? Yes No		
Calculate and administer corrective bolus? Yes No			Troubleshoot alar	ms and malfunctions?	Yes No		
Calculate and set basal profile	es? Yes	No	Calculate and set	Calculate and set temporary basal rate? Yes No			
Disconnect pump? Yes No			Reconnect pump at infusion set? Yes No Insert infusion set? Yes No				
Prepare reservoir and tubing?	Yes N	0					
INSULIN PRESCRIBED V	'IA INSU	ULIN 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 I	Insulin: '	Туре:		Dose:			
Meals and Snacks Eaten at							
Is student independent in carl	•		_	Yes No			
Daily Meal/Snack Food number	Ü	•					
Breakfast carbohydrate:	_	_	•	-			
Lunch carbohydrate:g		•	n snack carbohydra	_			
Dinner carbohydrate:	Ü		k carbohydrate:				
Snack before exercise? Yes	No	Snack after exc	ercise? Yes No	Estimate snack carboh	nydrates:gm		
Instructions for when food is	provided	l to the class (e.	g., as part of a class	s party or food sampling	g event):		
The following supplies	are to	be provided	l by parent/gua	rdian:			
Blood glucose mete	er, blood	glucose test st	rips, batteries for r	neter			
Lancet device, lance Urine ketone strips Insulin pump and s Insulin pen, pen ne Fast-acting source Carbohydrate conta	ets, glov	es, container f	or sharps disposal,	etc.			
Insulin pump and s	upplies						
Insulin pen, pen ne	edles, in of glucos	sulin cartridges se such as glute	s ose tablets or gluto	se gel			
Carbohydrate conta	ining sn	ack(s) (Provide	e meal if staying at	fter school.)	124 1 1		
Giucagon emergen	cy kit ioi	school hurse/	delegate. (II cilid l	is in sport need one for			
Note: If your child is sick an	<u>u jouowi</u>	ng atabetic st	uk aay ruies - ne/sh	z snouia remain nome i	<u>инш weн.</u>		
Parent/guardian signatur	re:			Date:/	/		

******	Physician/Nurse Pra	actitioner to complete	******
Work and/or Sports Conside	erations:		
Is student restricted from heig part of a pyramid and throwin working with hazardous mach there?	ng/catching stunts in che	erleading, spotting weigh	nt lifter, climbing ladders,
Needs to test FSBS test prior to	sports/exercise/work/driv	ing?□NO □YES Repe	at FSBS every hours.
Student should <u>NOT</u> exercise if large urine ketones are present.	blood glucose level is bel	ow mg/dl or above _	mg/dl OR if moderate to
YOU MAY SUBSTIT THE FOLLOWIN		IABETES MANAG : (must be signed by h	
Target range for blood glucose i	s: 70-150 or 70-18 0	0 or Other:	
Insulin Correction Doses			
Correction formula if blood su	gar is abovemg/dl	before meal. Circle one: H	umalog or Novolog or Apidra
Calculation of insulin units nee	ded to reach target blood	sugar:	
Premeal FSBS reading equal	to or above: ().	Subtract (target	blood glucose).
Then divide by Equ	als # of units needed. Ea	ach unit of insulin reduces	blood glucose bymg/dl.
Insulin to carbohydrate ratio?	No Yes If, "YES":		
Insulin:gi	ve units for every _	gm of carbohydrate	s eaten via: pump syringe
HYPERGLYCEMIA: Call parent/guardian if FSBS	or above. If <u>pre-meal</u>	result follow Insulin Cor	rection Dose formula orders.
Urine should be checked for ket	ones when blood glucose	levels is above mg	g/dl. or if vomiting.
Ketones (moderate-large) admir	nister (in addition to slidin	g scale insulin correction of	lose formula orders):
Insulin:do	ose:U and water or 0	Crystal lite oz per ho	ur.
HYPOGLYCEMIA: If FSBS belowmg/dl give: If symptomatic wait 15 minutes			• •
SEVERE HYPOGLYCEMIA Student is unable to swallow, or provide supply of Glucagon to s	is unconscious, or having	g a seizure Glucagon is to b	be given (parent/guardian is to
Route, Dosage	_, site for glucagon inject	ion:arm,	_thigh,other.
If Glucagon is required, the schostudent on his/her side. "911" v			
		MD. D	O, ANP, AP/
Print Name: Health Care Prov	vider S	Signature	Date

Child's Name:	D.O.B.:		<u>/</u>			
DIABETES MANAGEMENT PLAN IN SCHOOL A	GREEMENT A	ND RE	LEASE			
PARENT/GUARDIAN COMPLETES: I give permission and other designated staff members of Cape May County assist in the Diabetes Medical Management Plan for my team.	Technical School	ol to per	rform, to carry out, and/or to			
may need to know this information. I consent to the rele	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 of the school nurse is not available for after school activities, specification that may be in charge of an after school event or field triphis/her supplies available to manage his/her care. *	porting events, or	field tr	ips, I will inform adult staff			
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 glutose gel).						
PRINT NAME: Parent/Guardian Signa	ature		/			
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			_//			
						

Quick Reference Emergency Plan for a Student with Diabetes

Hypoglycemia (Low Blood Sugar) Photo

Student's Name					
Student's Name					
Grade/Teacher				Date of Plan	
Emergency Contact I	nformation:				
Mother/Guardian			Father/Guardian		
Home phone	Work phone	Cell	Home phone	Work phone	Cell
•	•		Tronto priono	,, o p	
School Nurse/Trained	l Diabetes Personne	1	Contact Number(s)	
	Never send	a child with suspect	ed low blood sugar a	nywhere alone.	
	Course of H	ypoglycemia			
		ch insulin		Onset	
	• Misse			Oliset	
		ed food	→ .	Sudden	
		o intense exercise			
		led exercise			
	• Unschedu	led exercise			
		Svr	nptoms	7	
		5,1			
Mild		M	oderate	*	Severe
	-				of consciousness
	veating owsiness	Headache Debassion	Blurry visionWeakness	• Seizur	
		Behavior			ity to swallow
	rsonality change		change • Slurred Speech		ity to swanow
	ability to	• Poor	Confusion		
	ncentrate	coordination	• Other		
	her:				
Dizziness					
Circle student's usu	al symptoms.	Circle studen	Circle student's usual symptoms.		ent's usual symptoms.
			\		_
			ns Needed		
Notify School				k blood sugar, per I	
	Management Pla	n. When in doubt, a	ilways TREAT FOR	HYPOGLYCEMIA	١.
			↓		
Mild			oderate		Severe
Student may/may		 Someone assists. 		 Don't attempt to give anything 	
Provide quick-sug		Cive student swiels sugar source		by mouth.	
3-4 glucose	tablets	 Give student quick-sugar source per MILD guidelines. 		• Position on	side, if possible.
4 oz. ju	iice	per MILD gu	idennes.	- Fosition on s	side, ii possible.
or		- W-'- 10 +- 15		Contact scho	ool nurse or trained
6 oz. regular soda		• Wait 10 to 15 minutes.		diabetes personnel.	
3 teaspoons of	glucose gel	Recheck bloo	d glucose.	1 1	
3 teaspoons of glucose gel					glucagon, as
Wait 10 to 15 minutes. Recheck blood glucose		 Repeat food if symptoms persist 		prescribed.	
 Recheck blood glucose. Repeat food if symptoms persist 		or blood gluce	or blood glucose is less than		
or blood glucose i		·		• Call 911.	
·		Follow with a	snack of	Contact pare	ents/guardian.
Follow with a sna			and protein (e.g.,		
carbohydrate and		cheese and cr		Stay with stu	ident.
 cneese and cracke 	TS1		*	1 1	

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

Quick Reference Emergency Plan for a Student with Diabetes

Hyperglycemia (High Blood Sugar)

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Student's Name						
Grade/Teacher				Date of Plan		
Emergency Contact I	nformation:					
Mother/Guardian			Father/Guardian			
Home phone	Work phone	Cell	Home phone	Work phone	Cell	
School Nurse/Trained	l Diabetes Personnel					
Contact Number(s)						
.,						
	Causes of Hy	perglycemia		Oward	7	
	Too much food	• Illness		Onset		
	Too little insulin		Over time	several hours or days		
	Decreased activi	ty • Stress] [
		Syr	mptoms			
			Ì			
			—			
Mi	ld		oderate		evere	
• Thirst			mptoms plus:	Mild and		
Frequent uFatigue/sle		Dry mo Nausea	uth	• Labored	symptoms plus: • Labored breathing	
Increased h		Stomacl	h cramps	Very weak		
Blurred vis		Vomitin		Confused		
Weight los		• Other:			 Unconscious 	
 Stomach p 	ains					
 Flushing of 						
• Lack of co						
• Sweet, frui	ty breath					
Other: Circle student's i	usual symptoms	Circle studen	t's usual symptoms.	Circle student	's usual symptoms.	
Circle distances a	l l	Circle Sinter	s diames symptoms.	Circle states	s usuu sympioms.	
	Y	Actio	ns Needed	*		
		use of the bathro	om.			
	 Encourage student to drink water or sugar-free drinks. 					
	Contact the school nurse or trained diabetes personnel to check					
	urine or administer insulin, per student's Diabetes Medical					
	Manageme		ting, or lethargic,	call the		
			l for medical assista			
	Parents/gua	a Gian Oi Cai	i ioi incuicai assista	nee ii parent		

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cannot be reached.