Sterling Park Day Camp

Medical Form Cover Sheet

Packet F

DIABETES Children

Here is a Sample Diabetes Action Plan and a Medical Management Plan that the doctor should put together for you.
Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of Plan: ____________ This plan is valid for the current school year: _____ - _____
Student's Name: ______________________ Date of Birth: ______________________
Date of Diabetes Diagnosis: __________ □ type 1 □ type 2 □ Other __________
School: ____________________________ School Phone Number: ____________
Grade: _______________ Homeroom Teacher: ____________________________
School Nurse: ______________________ Phone: ______________________

CONTACT INFORMATION
Mother/Guardian: ______________________
Address: ____________________________
Telephone: Home __________ Work __________ Cell: __________
Email Address: ______________________

Father/Guardian: ______________________
Address: ____________________________
Telephone: Home __________ Work __________ Cell: __________
Email Address: ______________________

Student's Physician/Health Care Provider: ______________________
Address: ____________________________
Telephone: ______________________
Email Address: ______________________ Emergency Number: ____________

Other Emergency Contacts:
Name: ______________________ Relationship: ______________________
Telephone: Home __________ Work __________ Cell: ______________________
CHECKING BLOOD GLUCOSE

Target range of blood glucose: □ 70–130 mg/dL □ 70–180 mg/dL
□ Other: ____________________________

Check blood glucose level: □ Before lunch □ _____ Hours after lunch
□ 2 hours after a correction dose □ Mid-morning □ Before PE □ After PE
□ Before dismissal □ Other: ____________________________

□ As needed for signs/symptoms of low or high blood glucose
□ As needed for signs/symptoms of illness

Preferred site of testing: □ Fingertip □ Forearm □ Thigh □ Other: ________
Brand/Model of blood glucose meter: ____________________________

Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:
□ Independently checks own blood glucose
□ May check blood glucose with supervision
□ Requires school nurse or trained diabetes personnel to check blood glucose

Continuous Glucose Monitor (CGM): □ Yes □ No
Brand/Model: ____________________________ Alarms set for: □ (low) and □ (high)

Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

HYPOGLYCEMIA TREATMENT
Student’s usual symptoms of hypoglycemia (list below):
__________________________________________________________

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 10–15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment: ____________________________
HYPOGLYCEMIA TREATMENT (Continued)

Follow physical activity and sports orders (see page 7).
- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
  - Glucagon: □ 1 mg □ 1/2 mg  Route: □ SC  □ IM
  - Site for glucagon injection: □ arm  □ thigh  □ Other: ______________________
  - Call 911 (Emergency Medical Services) and the student’s parents/guardian.
  - Contact student’s health care provider.

HYPERGLYCEMIA TREATMENT

Student’s usual symptoms of hyperglycemia (list below):

____________________________________________________________________________________

Check  □ Urine  □ Blood for ketones every _____ hours when blood glucose levels are above _____ mg/dL.

For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see orders below).

For insulin pump users: see additional information for student with insulin pump.

Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.

Additional treatment for ketones: ________________________________

Follow physical activity and sports orders (see page 7).
- Notify parents/guardian of onset of hyperglycemia.
- If the student has symptoms of a hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911 (Emergency Medical Services) and the student’s parents/guardian.
- Contact student’s health care provider.
INSULIN THERAPY

Insulin delivery device: [□] syringe  [□] insulin pen  [□] insulin pump

Type of insulin therapy at school:
[□] Adjustable Insulin Therapy
[□] Fixed Insulin Therapy
[□] No insulin

Adjustable Insulin Therapy

• Carbohydrate Coverage/Correction Dose:
  Name of insulin: __________

• Carbohydrate Coverage:
  Insulin-to-Carbohydrate Ratio:
  Lunch: 1 unit of insulin per _____ grams of carbohydrate
  Snack: 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example

\[
\frac{\text{Grams of carbohydrate in meal}}{\text{Insulin-to-carbohydrate ratio}} = \text{_____ units of insulin}
\]

• Correction Dose:
  Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____
  Target blood glucose = _____ mg/dL

Correction Dose Calculation Example

\[
\frac{\text{Actual Blood Glucose—Target Blood Glucose}}{\text{Blood Glucose Correction Factor/Insulin Sensitivity Factor}} = \text{_____ units of insulin}
\]

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose _____ to _____ mg/dL give _____ units
Blood glucose _____ to _____ mg/dL give _____ units
Blood glucose _____ to _____ mg/dL give _____ units
Blood glucose _____ to _____ mg/dL give _____ units
INSULIN THERAPY (Continued)

When to give insulin:

Lunch
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and ____ hours since last insulin dose.
- Other: ____________________________________

Snack
- No coverage for snack
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and ____ hours since last insulin dose.
- Other: ____________________________________

- Correction dose only:
  - For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.
- Other: ____________________________________

Fixed Insulin Therapy

Name of insulin: ____________________________________

- _____ Units of insulin given pre-lunch daily
- _____ Units of insulin given pre-snack daily
- Other: ____________________________________

Parental Authorization to Adjust Insulin Dose:

- Yes  ☐ No  Parents/guardian authorization should be obtained before administering a correction dose.

- Yes  ☐ No  Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.

- Yes  ☐ No  Parents/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate.

- Yes  ☐ No  Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.
INSULIN THERAPY (Continued)

Student’s self-care insulin administration skills:

☐ Yes  ☐ No  Independently calculates and gives own injections
☐ Yes  ☐ No  May calculate/give own injections with supervision
☐ Yes  ☐ No  Requires school nurse or trained diabetes personnel to calculate/give injections

ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP

Brand/Model of pump: ___________________  Type of insulin in pump: ________________

Basal rates during school: _______________________________________________________

Type of infusion set: ___________________________________________________________

☐ For blood glucose greater than ______ mg/dL that has not decreased within
   ______ hours after correction, consider pump failure or infusion site failure. Notify
   parents/guardian.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir.

☐ For suspected pump failure: suspend or remove pump and give insulin by syringe or
   pen.

Physical Activity

May disconnect from pump for sports activities  ☐ Yes  ☐ No

Set a temporary basal rate  ☐ Yes  ☐ No  ____% temporary basal for _____ hours

Suspend pump use  ☐ Yes  ☐ No

Student’s self-care pump skills:  Independent?

Count carbohydrates  ☐ Yes  ☐ No

Bolus correct amount for carbohydrates consumed  ☐ Yes  ☐ No

Calculate and administer correction bolus  ☐ Yes  ☐ No

Calculate and set basal profiles  ☐ Yes  ☐ No

Calculate and set temporary basal rate  ☐ Yes  ☐ No

Change batteries  ☐ Yes  ☐ No

Disconnect pump  ☐ Yes  ☐ No

Reconnect pump to infusion set  ☐ Yes  ☐ No

Prepare reservoir and tubing  ☐ Yes  ☐ No

Insert infusion set  ☐ Yes  ☐ No

Troubleshoot alarms and malfunctions  ☐ Yes  ☐ No
OTHER DIABETES MEDICATIONS

Name: ____________________ Dose: _______ Route: _______ Times given: _____
Name: ____________________ Dose: _______ Route: _______ Times given: _____

MEAL PLAN

<table>
<thead>
<tr>
<th>Meal/Snack</th>
<th>Time</th>
<th>Carbohydrate Content (grams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td>_________</td>
<td>to _________</td>
</tr>
<tr>
<td>Mid-morning snack</td>
<td>_________</td>
<td>to _________</td>
</tr>
<tr>
<td>Lunch</td>
<td>_________</td>
<td>to _________</td>
</tr>
<tr>
<td>Mid-afternoon snack</td>
<td>_________</td>
<td>to _________</td>
</tr>
</tbody>
</table>

Other times to give snacks and content/amount:

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

Special event/party food permitted:  □ Parents/guardian discretion  
                                       □ Student discretion

Student’s self-care nutrition skills:

□ Yes  □ No  Independently counts carbohydrates
□ Yes  □ No  May count carbohydrates with supervision
□ Yes  □ No  Requires school nurse/trained diabetes personnel to count carbohydrates

PHYSICAL ACTIVITY AND SPORTS

A quick-acting source of glucose such as □ glucose tabs and/or □ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat □ 15 grams  □ 30 grams of carbohydrate □ other _________
□ before  □ every 30 minutes during  □ after vigorous physical activity  
□ other ___________________________________________________________________

If most recent blood glucose is less than ________ mg/dL, student can participate in physical activity when blood glucose is corrected and above ________ mg/dL.

Avoid physical activity when blood glucose is greater than ________ mg/dL or if urine/blood ketones are moderate to large.

(Additional information for student on insulin pump is in the insulin section on page 6.)
DISASTER PLAN
To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.
☐ Continue to follow orders contained in this DMMP.
☐ Additional insulin orders as follows: ______________________________
☐ Other: ______________________________

SIGNATURES
This Diabetes Medical Management Plan has been approved by:

__________________________________________   __________________________
Student’s Physician/Health Care Provider   Date

I, (parent/guardian:) ___________________________ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school:) ___________________________ to perform and carry out the diabetes care tasks as outlined in (student:) ___________________________’s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child’s health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child’s physician/health care provider.

Acknowledged and received by:

__________________________________________   __________________________
Student’s Parent/Guardian   Date

__________________________________________   __________________________
Student’s Parent/Guardian   Date

__________________________________________   __________________________
School Nurse/Other Qualified Health Care Personnel   Date