Auburn Washburn
Unified School District 437

Shuler Education Center

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INFORMATION FOR DIABETES MANAGEMENT AT SCHOOL

Dear Parent,
Since you have shared with us that your child has diabetes, completion of the following will help us form a plan of care for school. We want to ensure effective treatment delivery and safety for your child while at school.

Student Name: _____ DOB:_____
Parent/Guardian: _____
Home Phone: _____Work:_____ Cell:_____
Emergency Contact: _____ Relationship:_____
Physician:_____ Phone:_____

Insulin Administration:
☐ Syringe and Insulin Vial Brand name: _____
☐ Insulin Pen ☐ Insulin Pump Other:_____

Insulin: AM _____ Lunch _____
(Time-Type-Amount) (Time-Type-Amount)

Dinner _____ Bedtime _____
(Time-Type-Amount) (Time-Type-Amount)

Will student require assistance with insulin administration? ☐ yes ☐ no
If so, please note what type of assistance is needed.
_____

For Students With Insulin Pumps:
Type of pump: _____ Basal rates: _____
Type of insulin in pump: _____
Type of infusion set: _____
Insulin/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills:	Needs Assistance
Count carbohydrates	☐ yes ☐ no
Bolus correct amount for carbohydrates consumed	☐ yes ☐ no
Calculate and administer corrective bolus	☐ 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 Diabetes Medications
Type of medication: _____ Time _____
Other medications: _____ Time:_____

Blood Glucose Testing:
Will student require routine glucose monitoring at school? ☐ yes ☐ no
Will student require assistance with routine glucose monitoring? ☐ yes ☐ no
If so, please note what type of assistance is needed._____
Time of day blood glucose should be routinely checked:_____
Type of glucometer:_____
Does student check urine for glucose? ☐ yes ☐ no

Insulin Dose Determined By:
Insulin-to-carbohydate ratio: _____ unit(s) of _____insulin per 1 carbohydrate (15gms.)
Additional instructions:_____

Sliding Scale for blood sugars greater than 240mg/dl
Blood Glucose from _____ to _____ = _____ units
Blood Glucose from _____ to _____ = _____ units
Correction Calculation: _____

Dietary Needs:
☐ Carbohydrate Counting Meal Plan
- ☐ A.M. snack consisting of _____ carbohydrates
- ☐ Lunch consisting of_____ carbohydrates
- ☐ P.M. snack consisting of _____ carbohydrates

☐ Does not follow any set meal plan. Counts carbohydrates and uses Insulin-to-carbohydrate ratio.
☐ Needs snack before or after P.E.

Physical Education: Scheduled at: _____ Snack before? ☐ yes ☐ no
(Parent will provide snacks for the student.)

Student will not participate in sports if ketones are present.

Hypoglycemia (Low Blood Sugar)
Usual symptoms:_____
Treatment:_____
Should Glucagon be given if the student becomes unconscious? _____
Site for injection_____ CALL 911 and notify parents immediately.

Hyperglycemia (High Blood Sugar)
Usual symptoms_____
Treatment_____
Should the student's urine be checked for ketones when the blood glucose levels are above _____ mg/dl.?
Treatment for ketones _____

Supplies to be kept at school
☐ Lancet device, lancets, etc.
☐ Urine ketone strips
☐ Insulin vials and syringes
☐ Glucagon emergency kit
☐ Blood glucose meter, blood glucose test strips, batteries for meter
☐ Insulin pump and supplies
☐ Insulin pen, pen needles, insulin cartridges
☐ Fast acting source of glucose
☐ Carbohydrate containing snack

Signatures
This Diabetes Medical Management Plan has been approved by:

_____ _____
Student's Physician/Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel and other designated staff members of _____ School to perform and carry out the diabetes care tasks as outlined by _____ 's Diabetes Medical Management Plan.

I also consent to the release of the information contained in this Plan to all staff members who have 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:

_____ _____
Student's Parent/Guardian Date

_____ _____
Student's Parent/Guardian Date