



The Molly Center for Children with Diabetes and Endocrine Disorders

Diabetes Management Plan

(To be completed by parent/guardian)

This plan should be completed by the student's parents/guardians and reviewed with school nurse and relevant school staff. Copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel. A student photo should be included with the plan.

Date of plan: _____ Plan is valid for the current school year: _____ - _____

Student information

Student's name: _____ Date of birth: _____
Date of diabetes diagnosis: _____ Type 1 Type 2 Other: _____
School: _____ School phone number: _____
Grade: _____ Homeroom teacher: _____
School nurse (s): _____ Phone: _____

Contact information

Parent/guardian 1: _____
Address: _____
Telephone: Home: _____ Work: _____ Cell: _____
Email address: _____

Parent/guardian 2: _____
Address: _____
Telephone: Home: _____ Work: _____ Cell: _____
Email address: _____

Student's diabetes MD/APN: _____
Address: _____

Telephone: 551-996-5329 – Option 2 for urgent calls. Option 3 for non-urgent medical calls.

For Emergencies call 911

Address: The Molly Center for Children with Diabetes and Endocrine Disorders
30 Prospect Avenue, Hackensack, NJ 07601

Other emergency contacts: Name: _____ Relationship: _____
Telephone: Home: _____ Work: _____ Cell: _____

Checking blood glucose

Brand/model of blood glucose meter: _____

Preferred site of testing: Side of fingertip Other: _____

Note: Site should always be cleaned with soap and water (preferred) or alcohol prior to checking; site should be dry prior to checking. The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Continuous glucose monitor (CGM): Yes No Brand/model: _____

Alarms set for: Severe Low: _____ Low: _____ High: _____

Predictive alarm: Low: _____ High: _____ Rate of change: Low: _____ High: _____

Additional information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level. If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-care CGM Skills	Independent?	
The student troubleshoots alarms and malfunctions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do and is able to deal with a HIGH alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do and is able to deal with a LOW alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student can calibrate the CGM if recommended	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The student should be escorted to the nurse if the CGM alarm goes off: Yes No

Hypoglycemia/Hyperglycemia treatment- See Diabetes Medical Management Plan (DMMP)

Student's usual symptoms of hypoglycemia (list below):

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

Insulin therapy

Insulin delivery device: Syringe Insulin pen Insulin pump

Brand/model of pump: _____ **Type of infusion set:** _____

For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen and call parent/guardian.

Meal plan

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		___ to ___
Mid-morning snack		___ to ___
Lunch		___ to ___
Mid-afternoon snack		___ to ___

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'/Guardians' discretion Student discretion

Student's self-care nutrition skills:

- Independently counts carbohydrates
 - May count carbohydrates with supervision
 - Requires school nurse/trained diabetes personnel to count carbohydrates
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Student's Self Care: (ability level to be determined by school nurse and parent with input from diabetes educator as needed. May be modified/updated on Individualized Health Plan during the school year.

Totally independent management	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates own insulin dose for snacks/meals	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Administers insulin independently	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Self-injects; needs verification of dose by staff	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Injections to be done by trained staff	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Checks BG independently	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Needs assistance/supervision by staff for BG checks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Self-treats mild hypoglycemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Monitors and interprets urine/blood ketones	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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.

Disaster plan

To prepare for an unplanned disaster or emergency, an emergency supply kit will be provided by parents/guardians.

Continue to follow orders contained in the DMMP. Discuss with parent/guardian the option for keeping long-acting insulin and syringes/pen at school. If long-acting insulin is not available in an emergency, blood sugar will be managed with rapid-acting insulin every 3 hours per DMMP.

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 the Diabetes Management Plan (DMP) and Diabetes Medical Management Plan (DMMP). I also consent to the release of the information contained in DMP and DMMP 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