Naperville 203 Community Unit School District

To be completed by Health Care Provider

DIABETES MANAGEMENT PLAN

Date of plan: This plan is valid for the current school year: _______–________

Student:	**DOB:**	**School/Grade:**
Physician:		**Phone:**
Emergency Phone:		**Fax:**

INSULIN PUMP: ☐Yes ☐ No **Insulin Pump Brand:** **Type of Insulin:**

PUMP SETTINGS:

TIME:	BASAL RATE (units per hour):	INSULIN to CARB RATIO: ______ unit(s) for every ______ grams of carbohydrates to be eaten	TARGET BLOOD GLUCOSE:	CORRECTION FACTOR: (Correction Factor Formula: Student's BG minus Target BG ÷ correction factor = insulin dose)

AT HOME:

Parent may change basal rate settings at home based on current BG data: ☐ Yes **(+ or - 0 to____ units**) ☐ No

Parent may change insulin to carb ratios settings at home based on current BG data:
☐Yes **(1 unit +/- _____ grams of carbohydrate**) ☐ No

DURING THE SCHOOL DAY:

Parent may request ☐ School Nurse and/or ☐student with supervision change a **basal rate**:
☐ Yes **(+ or - 0 to____ units**) ☐ No

Parent may request ☐ School Nurse and/or ☐student with supervision set a **temporary basal** (% or units/hr and time/length at parent discretion): ☐ Yes ☐ No

The student is permitted to independently provide all diabetes management: ☐ Yes ☐ No

INSULIN BOLUS PER PUMP:

Administer insulin per pump calculations for carbohydrate coverage: ☐ morning snack ☐ lunch ☐other _______

Administer BG correction bolus per pump calculation: ☐ Yes ☐ No

Parent may request that ☐ School Nurse and/or ☐student with supervision override pump calculations for BG correction: ☐ Yes **(+ or - 0 to____ units**) ☐ No

Parent may request that ☐ School Nurse and/or ☐student with supervision override the pump calculations for Insulin to Carb Ratio: ☐ Yes **(1 unit +/- _____ grams of carbohydrate**) ☐ No

Parent may request that ☐ School Nurse and/or ☐student with supervision to administer **combo boluses** at meals (% of amount and length of time per parent): ☐ Yes ☐ No

CHECKING BLOOD GLUCOSE:

Before Lunch ☐ Finger stick ☐CGM ☐Not required

Before PE ☐ Finger stick ☐CGM ☐Not required

Before Recess ☐ Finger stick ☐CGM ☐Not required

End of school Day ☐ Finger stick ☐CGM ☐Not required

Other______________________ ☐ Finger stick ☐ CGM

CGM Brand and Model:________________________

No PE if BG is >_____mg/dl or <___________mg/dl

BG must be > _____ for dismissal from school

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Hypoglycemia Treatment:

Treat if blood glucose is <_____________mg/dl or symptomatic

☐Give 15 grams of carbohydrates, wait 15 mins and recheck if <________mg/dl. Repeat

☐Give______grams of carbohydrates, wait ______min and recheck if <_________mg/dl. Repeat

If the child becomes unconscious, unable to cooperate or has a seizure, give Glucagon subcutaneously. Call 911 and parents. Do not force eating or drinking. Turn on side.

☐0.5mg Glucagon

☐1.0mg Glucagon

Hyperglycemia Treatment:

Treat if blood glucose is >_____________mg/dl or symptomatic

☐Check Ketones if blood glucose is >______________mg/dl

☐Pump Users: Check pump and site-if ok: Follow pump instructions for treatment

☐Non-Pump User: Give insulin based on correction factor if more than 2 hours since last dose of insulin

☐Other____

Student's Self-Care Skills	Independent?
Counts carbohydrates:	☐ Yes ☐ No
Calculates correct amount of insulin for carbohydrates consumed:	☐ Yes ☐ No
Administers correction bolus:	☐ Yes ☐ No
Calculates and sets basal profiles:	☐ Yes ☐ No
Calculates and sets temporary basal rate:	☐ Yes ☐ No
Changes batteries:	☐ Yes ☐ No
Disconnects pump:	☐ Yes ☐ No
Reconnects pump to infusion set:	☐ Yes ☐ No
Prepares reservoir, pod, and/or tubing:	☐ Yes ☐ No
Inserts infusion set:	☐ Yes ☐ No
Troubleshoots alarms and malfunctions:	☐ Yes ☐ No

☐I hereby certify that my child can monitor and manage his/her care without supervision from school staff except in emergencies.

☐I hereby certify that the above information is complete and I have provided the school with all information that they will need to reasonably care for and monitor my child's health related to his/her diabetes. I give permission for the school to talk to my doctor, nurse practitioner, and/or physician's assistant and/or nurse.

Signature and dates:

Parents_____________________________________ **Student** ___________________ **Date** ______________

Physician_________________________ **Date** ___________ Physician Stamp Here (address/phone):