DIABETES CARE AND TREATMENT PLAN

The student's physician and parent/guardian should complete this form. The completed plan will be reviewed by the school nurse, unlicensed diabetes care assistants and other authorized personnel.

PART A. THIS SECTION TO BE COMPLETED BY A MEDICAL AUTHORITY LICENSED BY THE STATE OF TEXAS TO WRITE MEDICAL PRESCRIPTIONS

Student's Name: ____ **Date of Birth:** ________ Effective Date:____________
DIABETES DIAGNOSIS: Type 1: ___ Type 2: ___ Gestational: ___ Age of Onset:___

BLOOD GLUCOSE MONITORING: Target Blood Glucose: _______mg/dl
Target range for blood glucose: _______ mg/dl to _______ mg/dl Type of blood glucose meter student uses:______________
Usual times to test blood glucose: _______
Time to do extra tests (check all that apply): ___ Before exercise ___When student exhibits symptoms of hyperglycemia
___ After exercise ___When student exhibits symptoms of hypoglycemia
Other (explain): ____
Can student perform own blood glucose test? YES ___ NO ___ Exceptions

INSULIN: Times, types, and dosages of insulin to be given during school:
Time: ____________ Type of Insulin: _______________________ Dose: ____________
Time: ____________ Type of Insulin: ________________ Dose: ____________

If Flexible dosing is used:
Time:_______Type of Insulin:________________________Dose:___________Units/______________grams of carbohydrates
Can student give own injections? YES ___ NO ___ Exceptions: ____
Can student determine correct amount of insulin? YES___ NO___ Can student draw correct dose of insulin? YES___ NO___
Insulin Correction Dose: Give ____units of _____insulin SQ for blood glucose ________mg/dl above ________mg/dl or Blood glucose below ________________mg/dl = no additional insulin
__________ units of ___________Insulin subcutaneously if blood glucose is ________ to ________mg/dl
__________ units of ___________Insulin subcutaneously if blood glucose is ________ to ________mg/dl
Notify **parent** if blood glucose is over __________mg/dl Notify **doctor** if blood glucose is over _________mg/dl

INSULIN PUMPS:
Basal rates: _______________________ ______________12am to _______________________________________
Type of Insulin in Pump: _______________ Type of Infusion Set:___________
Insulin/Carbohydrate ratio: _____________ Correction factor: _______
Is student competent regarding pump? Yes___ No___ Can student effectively troubleshoot problems? Yes___ No___

FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS:
Time: ________Name of Medication. ____Dose: ________________
Time: ________Name of Medication. ____Dose: ________________

UNABLE TO SWALLOW, LOSS OF CONSCIOUSNESS, OR SEIZURE:
___ Glucose gel, 1 mg. of Glucagon IM or Sub-Q and Call 9 -1-1

EXERCISE AND SPORTS:
Restrictions on activity, if any: ____
Students should not exercise if blood glucose is below ___ mg/dl or above ___mg/dl if moderate to large amounts of ketones are present

THIS DIABETES MEDICAL MANAGEMENT PLAN HAS BEEN APPROVED BY:

____ ______________________
Physician's Signature Date

____________________________ ______________________
Phone number Fax number

____ ______________________
Name of Physician's Diabetes Educator Phone number

AUSTIN Independent School District | Health Services and Nursing

DIABETES CARE AND TREATMENT PLAN (continued)

PART B: THIS SECTION TO BE COMPLETED BY A PARENT/ LEGAL GUARDIAN

Student's Name: ____ Date of Birth:____________________

School: ____ Grade: ______ Student ID#: _______________

Rides School Bus: Yes ____ No ____ Bus #: _______ Takes Glucophage or Glucotrol Yes ___No ___

Particular concerns:____

Insulin Delivery Method: Injections ___ Insulin pump ___ Combine glucose monitoring/insulin system: ____

Other Information: ____

Parent/Guardian #1: __________________________________ Address:____________________________________

Home Phone #: _______________________ Work #: _______________________ Cell #:_____________________

Parent/Guardian #2: __________________________________ Address:____________________________________

Home Phone #: _______________________ Work #: _______________________ Cell #: _____________________

Emergency Contact: __________________________________Relationship: _________________________________

Home Phone #: _______________________ Work #: _______________________ Cell #: _____________________

Physician name: ____ Phone #: _______________________

Does the student wear a medical alert bracelet/necklace? YES ___ NO ___

PARENT AUTHORIZATION SIGNATURE:

As parent/guardian of the above named student, I give permission for use of this health plan and for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

I also give permission to the School Nurse, the Unlicensed Diabetes Care assistant (UDCA) and any other designated staff members of my child's school to perform and carry out the diabetes care tasks as outlined by child's Diabetes Management and Treatment Plan. I also consent to the release of the information contained in this Diabetes Management Treatment Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

I agree to provide the school with all the supplies and medication(s) necessary to carry out the treatment plan for my child as indicated by my child's physician/healthcare provider.

I also agree to notify the school should there be any changes to my child's treatment plan at any time throughout the school year.

SIGN HERE

____ ________________________________ ____________

Parent/guardian signature | Parent/guardian name (print) | Date

My child is knowledgeable in the management of his/her diabetes and it is my wish that he/she can be allowed to manage his/her diabetes independently while at school or at an off campus event. My child will seek assistance from the school nurse or diabetes care attendant as needed or in the event of a medical emergency.

PARENT SIGNATURE: ____ **DATE:** ____________________

STUDENT SIGNATURE: ____ **DATE:** ____________________

This diabetes management plan has been reviewed by the school nurse and unlicensed diabetes care assistant.

____ ____________________

School Nurse Signature | Date

____ ____________________

Unlicensed Diabetes Care Assistant Signature | Date

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