Diabetes Medical Management Plan

EDMOND PUBLIC SCHOOLS

Student Information

Date of Plan_____ School Year _____

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

Student's Name: _____
Date of Birth _____ Date of Diabetes Diagnosis: _____
Grade: _____ Homeroom Teacher: _____
Physical Condition: _☐_ Diabetes Type 1 _☐_ Diabetes Type 2

Contact Information

Mother/Guardian: _____
Address: _____
_____
Telephone: Home _____ Work _____ Cell_____

Father/Guardian: _____
Address: _____
_____
Telephone: Home _____ Work _____ Cell_____

Student's Doctor/Health Care Provider:
Name: _____
Address: _____
_____
Telephone: _____ Emergency Number: _____

Other Emergency Contacts:
Name: _____
Relationship: _____
Telephone: Home _____Work _____ Cell_____

Notify parents/guardian or emergency contact in the following situations:

_____
_____
_____
_____

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Student Diabetes Competency Statement

Blood Glucose Monitoring

Can student perform own blood glucose checks? ☐ Yes ☐ No
Can student verify the reading without adult supervision? ☐ Yes ☐ No
Exceptions: _____
Type of blood glucose meter student uses: _____

Insulin

Can student give own injections? ☐ Yes ☐ No
Can student calculate correct dosage of insulin without adult supervision? ☐ Yes ☐ No
Can student fill syringe with or dial insulin pen to the correct dose of insulin without adult supervision? ☐ Yes ☐ No

Parents are authorized to adjust the insulin dosage under the following circumstances:

_____

For Students with Insulin Pumps

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 basal profiles	☐ 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

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of Edmond Public Schools to perform and carry out the diabetes care tasks as outlined by the **Edmond Public School Student Diabetes Competency Statement** and (Student's name) _____'s Diabetes Medical Management Plan from (Physician or Clinic) _____. I, also, consent to the release of the information contained in this Diabetes Medical Management 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.

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Physician Signature Date

Acknowledged and received by:

_____ _____
School Nurse Date