MONMOUTH COUNTY PARK SYSTEM

Diabetes Medical Management Plan

This plan should be completed by the participant's diabetes health care team and should be updated annually and as changes occur.

Participant's Name _____ Date of Birth _____

Date of Diabetes Diagnosis_____ ☐ Type 1 ☐ Type 2 ☐ Other _____

CONTACT INFORMATION

Mother/Guardian _____

Address_____

Home Phone_____Cell_____Work_____

Email Address _____

Father/Guardian _____

Address _____

Home Phone_____Cell_____Work_____

Email Address _____

Other Emergency Contact _____

Name Relationship _____

Home Phone Cell Work _____

Participant's Physician/Health Care Provider _____

Address_____

Telephone Emergency Number _____

Email Address _____

CHECKING BLOOD GLUCOSE

Target range of blood glucose: ☐ 70-130 mg/dL ☐ 70-180 mg/dL

☐ Other _____

Check blood glucose level *(please check)*:

☐ Before lunch _____ Hours after lunch
☐ Before snack _____ Hours after snack
☐ As needed for signs/symptoms of low or high blood glucose
☐ As needed for signs/symptoms of illness
☐ Other _____

Preferred site of testing: ☐ Fingertip ☐ Forearm ☐ Thigh ☐ Other _____

Brand/Model of blood glucose meter _____

Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Participant's self-care blood glucose checking skills:

Independently checks own blood glucose ☐ Yes ☐ No

May check blood glucose with supervision ☐ Yes ☐ No

Requires trained diabetes personnel to check blood glucose ☐ Yes ☐ No

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No

Brand/Model Alarms set for: _____ ☐ Low ☐ High

Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If participant has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

HYPOGLYCEMIA TREATMENT

Participant's usual symptoms of hypoglycemia *(please list below)*:

_____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than ____ mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 10-15 minute and repeat treatment if blood glucose level is less than _____ mg/dL.

Note: Follow physical activity and sports orders (see page7)

HYPOGLYCEMIA TREAMENT (Continued)
Additional treatment: _____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions, give:

☐ Glucagon ☐ 1 mg ☐ ½ mg

Route: ☐ SC ☐ IM

Site for glucagons injection: ☐ arm ☐ thigh ☐ other

☐ Call 911 (Emergency Medical Services) and the participant's parent/guardian.

☐ Contact the participant's health care provider.

HYPERGLYCEMIA TREATMENT

Participant's usual symptoms of hyperglycemia *(please list below)*:

_____

_____

Check for keytones every _____ hours when blood glucose levels are above _____ mg/dL.:
☐ Urine

☐ Blood

For blood glucose greater than _ mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see orders below).
Give extra water and/or non-sugar containing drinks (not fruit juices):. ____ ounces per hour

Additional treatment for keytones: _____

☐ Notify the parents/guardians of onset of hyperglycemia.

☐ If the participant has symptoms of a hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911 (Emergency Medical Services) and the participant's parent/guardian.

☐ Contact the participant's health care provider.

For insulin pump users: see additional information for participants with insulin pump (page 6)
Follow physical activity and sports orders (page 7)

INSULIN THERAPY

Insulin delivery device: ☐ syringe ☐ insulin pen ☐ insulin pump

Type of insulin therapy at program/camp:

☐ Adjustable Insulin Therapy

☐ Fixed Insulin Therapy

☐ No insulin

Adjustable Insulin Therapy

Carbohydrate Coverage/Correction Dose

Name of insulin: _____

Carbohydrate Coverage

Insulin-to-Carbohydrate Ratio:

Lunch: 1 unit of insulin per _____ grams of carbohydrate
Snack: 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example

Grams of carbohydrate in meal /
Insulin-to-carbohydrate ratio
= _____ *units of insulin*

Correction Dose

Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____
Target blood glucose = ___ mg/dL

Correction Dose Calculation Example
Actual Blood Glucose - Target Blood Glucose /
Blood Glucose Correction Factor/Insulin Sensitivity Factor
= _____ *units of insulin*

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose ____ to __ mg/dL give _____ units
Blood glucose ____ to __ mg/dL give _____ units
Blood glucose ____ to __ mg/dL give _____ units
Blood glucose ____ to __ mg/dL give _____ units

When to give insulin:
Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than ___ mg/dL and _____ hours since last insulin dose.

☐ Other _____

Snack

☐ No coverage for snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than ___ mg/dL and ____ hours since last insulin dose.

☐ Other _____

☐ Correction dose only:

For blood glucose greater than _____ mg/dL and at least _____ hours since last insulin dose.

☐ Other _____

Fixed Insulin Therapy

Name of insulin

☐ _____ Units of insulin given pre-lunch daily
☐ _____ Units of insulin given pre-snack daily
☐ Other

Participant's self-care insulin administration skill:

Independently calculates and gives own injections	☐ Yes	☐ No
May calculate/give own injections with supervision	☐ Yes	☐ No
Requires trained diabetes personnel to calculate/give injections	☐ Yes	☐ No

ADDITIONAL INFORMATION FOR PARTICIPANT WITH INSULIN PUMP

Brand/Model of pump _____ Type of insulin in pump _____

Basal rates during program/camp _____
Type of infusion set _____

Please check:

☐ For blood glucose greater than _____ mg/dL that has not decreased within ___ hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.

☐ For infusion site failure: Insert new fusion set and/or replace reservoir.

☐ For suspected pump failure: suspend of remove pump and give insulin by syringe or pen.

Physical Activity

May disconnect from pump for sports activities ☐ Yes ☐ No

Set a temporary basal rate ☐ Yes ☐ No

____ % temporary basal for _____ hours
Suspend pump use ☐ Yes ☐ No

Participant's self-care pump skills: *Can the Participant do the following independently?*

Count carbohydrates	☐ Yes ☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes ☐ No
Calculate and administer correction bolus	☐ Yes ☐ No
Calculate and set basal profiles	☐ Yes ☐ No
Calculate and set temporary basal rate	☐ Yes ☐ No
Change batteries	☐ Yes ☐ No
Disconnect pump	☐ Yes ☐ No
Reconnect pump to infusion set	☐ Yes ☐ No
Prepare reservoir and tubing	☐ Yes ☐ No
Insert infusion set	☐ Yes ☐ No
Troubleshoot alarms and malfunctions	☐ Yes ☐ No

OTHER DIABETES MEDICATIONS

Name _____ Dose _____ Route _____ Times given _____
Name _____ Dose _____ Route _____ Times given _____

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 part of the program (i.e. cooking project as a scheduled activity):

_____

Participant's self-care nutrition skills:

Independently counts carbohydrates ☐ Yes ☐ No

May count carbohydrates with supervision ☐ Yes ☐ No

Requires trained diabetes personnel to count carbohydrates ☐ Yes ☐ No

PHYSICAL ACTIVITY AND SPORTS

A quick-acting source of glucose must be available at the site of physical activities and sports:

☐ glucose tabs

☐ sugar containing juice

Participant should eat: ☐ 15 grams ☐ 30 grams of carbohydrate ☐ other _____
☐ before ☐ every 30 minutes during ☐ after vigorous play ☐ other _____

If most recent blood glucose is less than_____mg/dL, participant can participate in physical activity when blood glucose is corrected and above_____mg/dL.

Avoid physical activity when blood glucose is greater than_____mg/dL or if urine/blood ketones are moderate to large.

Physician/Health Care Provider Signature _____ ***Date*** _____

I give permission for trained Monmouth County Park System staff to administer the above medication(s).

Parent/Guardian Signature _____ ***Date*** _____