



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 GLUCOSETarget 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 NoMay check blood glucose with supervision Yes NoRequires trained diabetes personnel to check blood glucose Yes No**Continuous Glucose Monitor (CGM):** Yes NoBrand/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 TREATMENT (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 ketones 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 ketones: _____

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 NoSet 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 NoBolus correct amount for carbohydrates consumed Yes NoCalculate and administer correction bolus Yes NoCalculate and set basal profiles Yes NoCalculate and set temporary basal rate Yes NoChange batteries Yes NoDisconnect pump Yes NoReconnect pump to infusion set Yes NoPrepare reservoir and tubing Yes NoInsert infusion set Yes NoTroubleshoot 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.

(Additional information for participant on insulin pump is in the insulin section on page 6)

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



MONMOUTH COUNTY PARK SYSTEM MEDICATION AUTHORIZATION FORM

Participant's Name: _____ **Date of Birth:** _____

We highly recommend and encourage that medications be administered prior to or after the camp session, however; we recognize that there may be occasions where medicine may need to be administered with supervision during the camp day. Any medication other than rescue medications (benadryl with epi-pen, epi-pen, or asthma inhaler) will only be administered with supervision at a location where a camp nurse is present such as Dorbrook Recreation Area.

1. All prescription and non-prescription medication (over the counter) require a physician's authorization and shall be labeled and stored in the original prescription container.
2. All medication is maintained under staff supervision and the staff supervises the administration of this medication. The only exception to this is Asthma inhalers, which may be carried on the person, but must be clearly labeled with doctor's protocol.
3. Parents/Guardians must sign the medication authorization form below.

Parental Request

I, the parent/guardian of _____ request that the rescue/prescription medication prescribed by my child's physician be administered to my child by a trained staff member (for rescue medications only such as epi-pens, benadryl with epi-pens or asthma inhalers) or the camp nurse (for other prescribed medications for campers at Dorbrook Recreation Area). The medication will be brought to camp in its original container appropriately labeled by my pharmacy.

Signature of parent/guardian

Date

Address

Home Phone Number

City

State

Zip

Cellular Number

Physician's Authorization

In order to protect the health of, _____ it is necessary for him/her to have the
Following medication during camp hours.

MEDICATION: _____

DOSAGE: _____

TIME to be administered: _____

Purpose of medication: _____

List any possible side effects: _____

I authorize the camp nurse or qualified staff member to administer the above medication.

Signature of Physician _____ Date _____

Address _____