



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 TREATMENTParticipant'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 NoMay calculate/give own injections with supervision Yes NoRequires 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 or remove pump and give insulin by syringe or pen.

Physical ActivityMay 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** _____