



South Brunswick School District
Diabetes Medical Management Plan

Date: \_\_\_\_\_

Dear Doctor:

Please review the parent/guardian questionnaire and complete, sign and stamp this Diabetes Medical Management Plan. We will work with you to accommodate his/her management needs during school activities.

STUDENT NAME: \_\_\_\_\_ Grade: \_\_\_\_\_

CURRENT INSULIN REGIMEN:

- Pump \_\_\_\_\_ Pen \_\_\_\_\_ Syringe \_\_\_\_\_
• Student can give his/her own insulin: Yes \_\_\_\_\_ No \_\_\_\_\_
o If yes, student will need supervision giving own insulin: Yes \_\_\_\_\_ No \_\_\_\_\_
o If no, see Medication Order Form - with instructions for medication administration during school hours
• Usual Lunchtime Dose
o Base dose of Humalog/Novolog /Regular (circle type) insulin at lunch is \_\_\_\_\_ units, or does flexible dosing using \_\_\_\_\_ units/ \_\_\_\_\_ grams carbohydrate.
o Use of other insulin at lunch (circle) intermediate/NPH/Lente \_\_\_\_\_ units, or basal/Lantus/Ultralente \_\_\_\_\_ units.
• Insulin Correction Doses
o \_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl
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• For Students with Insulin Pumps:
o Type of pump: \_\_\_\_\_ Type of insulin in pump \_\_\_\_\_ Type of infusion set: \_\_\_\_\_
o Basal rates: \_\_\_\_\_ 12 am to \_\_\_\_\_
\_\_\_\_\_ to \_\_\_\_\_
\_\_\_\_\_ to \_\_\_\_\_
o Insulin/carbohydrate ratio: \_\_\_\_\_ Correction factor: \_\_\_\_\_
• Parents are authorized to adjust the insulin dosage: \_\_\_Yes \_\_\_No

ACTIVITY & EXERCISE:

- Activity should be delayed or avoided if the blood glucose is higher than \_\_\_\_\_ mg/dl or lower than \_\_\_\_\_ mg/dl.
• Please specify any conditions under which this child should not exercise or participate in sports:

\_\_\_\_\_

HYPOGLYCEMIC EMERGENCY PROTOCOL:

- Administer emergency medications:

Table with 3 columns: Medication, Dosage, Time

- Other Instructions:

\_\_\_\_\_

This Diabetes Medical Management Plan has been approved by:

\_\_\_\_\_ Date: \_\_\_\_\_
Student's Physician/Health Care Provider Signature & Stamp