



**EL PASO INDEPENDENT SCHOOL DISTRICT**

**Diabetes Management and Treatment Plan  
(To be included with IHP)**

Date of Plan: \_\_\_\_\_ School Year: \_\_\_\_\_

This plan should be completed by the student's physician and parent/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, unlicensed diabetes care assistants and other authorized personnel.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Homeroom Teacher/Grade: \_\_\_\_\_

Date of Diabetes Diagnosis: \_\_\_\_\_

**Contact Information:**

Mother/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Student's Doctor/Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

**Other Emergency Contacts:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Does student wear a medical alert bracelet / necklace? \_\_\_\_\_

**Middle School and High School Student current schedule must be attached.**

**Blood Glucose Monitoring:**

Type of blood glucose meter student uses: \_\_\_\_\_

Target range for blood glucose: \_\_\_\_\_

Usual times to check blood glucose: \_\_\_\_\_

When to do extra blood glucose checks:

\_\_\_\_ Before exercise

\_\_\_\_ After exercise

\_\_\_\_ When student exhibits symptoms of hyperglycemia or hypoglycemia

\_\_\_\_ Other (explain) \_\_\_\_\_





Preferred snack foods: \_\_\_\_\_  
Foods to avoid, if any: \_\_\_\_\_  
Instructions for when food is provided to the class (e.g. as part of a class party or food sampling):  
\_\_\_\_\_

**Exercise and Sports:**

A fast-acting carbohydrate such as \_\_\_\_\_ or \_\_\_\_\_ should be available at the site of exercise or sports.  
Restrictions on activity, if any: \_\_\_\_\_  
Students should not exercise if blood glucose is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl or if moderate to large ketones are present.

**Hypoglycemia (Low Blood Sugar)**

Usual symptoms of hypoglycemia:  
\_\_\_\_\_  
\_\_\_\_\_

Treatment of hypoglycemia:  
\_\_\_\_\_  
\_\_\_\_\_

Glucagon should be given if the student is unconscious, having a seizure (convulsion) or unable to swallow. Route \_\_\_\_\_, Dose \_\_\_\_\_, Site \_\_\_\_\_  
If glucagon is required, administer promptly. Then call 911 and the parent/guardian.

**Hyperglycemia (High Blood Sugar)**

Usual symptoms of hyperglycemia:  
\_\_\_\_\_  
\_\_\_\_\_

Treatment of hyperglycemia:  
\_\_\_\_\_  
\_\_\_\_\_

Urine should be checked for ketones when blood glucose levels are above \_\_\_\_\_ mg/dl.  
Treatment for ketones: \_\_\_\_\_

**Supplies to be Provided by Student:**

- \_\_\_\_\_ Blood glucose meter, blood glucose test strips, batteries for meter
- \_\_\_\_\_ Lancet device, lancets, alcohol wipes
- \_\_\_\_\_ Urine ketone strips
- \_\_\_\_\_ Insulin vials and syringes
- \_\_\_\_\_ Insulin pen, pen needles, insulin cartridges
- \_\_\_\_\_ carbohydrate containing snack
- \_\_\_\_\_ Insulin pump and supplies
- \_\_\_\_\_ Fast-acting source of glucose
- \_\_\_\_\_ Glucagon emergency kit

Student Name: \_\_\_\_\_

**Student's Level of Self-Care:**

The student's current ability to perform various diabetes self-management skills is indicated by activities checked in the chart below:

<b>Student's Level of Self Care</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
1) Totally independent management (only requires assistance during severe hypoglycemia).			
2) Student tests blood glucose level independently.			
3) Student needs verification of blood glucose levels by nurse or the UDCA.			
4) Blood glucose testing to be done by the nurse or UDCA.			
5) Student administers insulin independently.			
6) Student self-injects insulin with verification of dosage by nurse or UDCA.			
7) Insulin injections to be done by the nurse or UDCA.			
8) Student self-treats mild hypoglycemia.			
9) Student requires assistance to treat mild hypoglycemia from the nurse / UDCA.			
10) Student monitors own snacks / meals.			
11) Snacks / meals to be supervised by nurse and/or UDCA.			
12) Student tests & interprets own urine ketones.			
13) Urine ketones to be tested by nurse / UDCA.			
14) Student implements universal precautions & demonstrates appropriate storage/disposal of sharps.			
15) Universal precautions & appropriate storage & disposal of sharps to be supervised by the nurse / UDCA.			

If student is not acting responsibly, testing will be confirmed to the nurse's office until skills/knowledge is learned.

Other Orders:

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Student Name: \_\_\_\_\_



**This Diabetes Medical Management Plan has been approved by:**

\_\_\_\_\_  
Student's Physician Signature

\_\_\_\_\_  
Date

I give permission to the School Nurse, the Unlicensed Diabetes Care Assistant (UDCA) and any other designated staff members of \_\_\_\_\_ school to perform and carry out the diabetes care tasks as outlined by \_\_\_\_\_'s Diabetes Management and Treatment Plan. I also consent to the release of the information contained in this Diabetes Management and Treatment 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. I also understand that according to Chapter 168.009 of House Bill 984, Immunity From Disciplinary Action or Liability: a) A school employees may not be subject to any disciplinary proceeding, resulting from an action taken in compliance with the subchapter. The requirements of the subchapter, "Care of Students with Diabetes," are considered to involve the employee's judgement and discretion and are not considered ministerial acts for purposes of immunity from liability under Section 22.0511, Education Code; b) A school nurse is not responsible for and may not be subject to disciplinary action under Chapter 301, Occupations Code, for actions performed by an unlicensed diabetes care assistant.

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**My child can manage his/her diabetes completely independently and will NOT seek assistance for his/her diabetes while at school.**

**Yes \_\_\_\_\_ No \_\_\_\_\_**

\_\_\_\_\_  
Student's Parent/Guardian Signature

\_\_\_\_\_  
Date

**Student Name:** \_\_\_\_\_

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