2021-2022 Personal Diabetes Medical Management Plan
Please complete **ALL BLANK AREAS**.
YOU WILL BE RESPONSIBLE FOR GETTING THIS PLAN TO YOUR CHILD'S SCHOOL.
For provider signature, please fax form to **# 317-948-2760** or email to **diabhelp@iupui.edu** or **mail** to ATTN: Riley Hospital Diabetes Team
705 Riley Hospital Drive, Room #5960, Indianapolis IN 46202.
****ALLOW 1-2 WEEKS TO PROCESS ****

Date Form Completed: ________________

Diabetes Physician's Name: ________________________________

Student Name: ________________________________ **DOB:** ________________

Type of Diabetes: ☐**Type 2**

Parent Name & Phone Number: ____________________ _______________________

Name of School and City:________________________ __________________________

School Phone Number: __________________________**School Fax Number:**__________

Parent Email:______________________________

School's Nurse E-mail: ____

This student is currently managed by following a healthy meal plan, exercise plan, and taking metformin. Below are the guidelines for diabetes management during the school day.

Meal Plan: Carb limit as outlined below. Avoid highly sweetened foods and drinks. For special parties, sweets may be eaten if included in carb limits. Carbs not eaten at one meal can be included in next meal/snack.

Breakfast: ______________gram max

Lunch: _________________gram max

Snacks:__________________gram max

Activity: Children with type II diabetes benefit from following a routine exercise plan including daily exercise. There is no activity restriction because of the diabetes.

Blood sugar testing:

☐ Testing blood sugar twice daily but only at home at this time. No blood sugar checks are required at school.

OR

☐ Testing blood sugar prior to each meal. Please check blood sugar before breakfast (if eats at school) and before lunch.

If student shows unusual behavior or is feeling ill, please also check sugar at that time.

Please record all blood sugars taken and notify parent/Riley Diabetes Team if more than half of the readings are over 150.

Medication: Please discuss with parent if metformin should be given at school with breakfast. Otherwise, it will be given at home. Metformin does not cause low blood sugar, however it may cause GI upset and diarrhea.

Authorization to Release and Disclose Patient Information

By signing this authorization, I am allowing my student's health care practitioner and/or organization to release my student's medical information to the school. I understand that the health care practitioner will directly release to the school a diabetes management and treatment plan, and may answer other questions for the school as necessary for the treatment and care of my student while in the care of the school. This information may be released throughout the year whenever a change to the management and treatment plan is required. I also understand that the health care practitioner will rely on the information I provide regarding the name and contact information for the school. The following conditions apply:

- This authorization will expire at the end of the designated school year unless otherwise specified.
- I understand that I have a right to revoke this authorization at any time. In order to revoke this authorization,
- I must do so in writing and present my written revocation to health care organization. The revocation will not apply to information that has already been released in response to this authorization.
- I understand that I am not required to sign this Authorization in order to receive health care treatment.
- The health care practitioner and/or organization cannot prevent redisclosure of your information by the person or organization who receives your records under this Authorization and that information may not be covered by state and federal privacy protections after it is released. By signing this Authorization, you release the health care practitioner and/or organization from any and all liability resulting from a redisclosure by the recipient.

Your signature indicates that you have read and understand this form and agree to the plan, and you authorize the release of the information as described above.

12. PARENT PLEASE SIGN (once reviewed):

______________________________ ______________________________

Parent's Signature Date Signed

13. LICENSED HEALTH CARE PRACTITIONER:

______________________________ ______________________________

Provider's Signature Date Signed

(p) 317-944-0274

(f) 317-948-2760

(e) diabhelp@iupui.edu