

# Medical Management Plan (Diabetes)



## Welcome!

Thank you for registering to participate with the Raleigh Parks, Recreation and Cultural Resources Department (PRCR). The City is committed to providing all participants with an exceptional experience. The City has received your request for accommodation, and it is important that we engage you as a partner in the process to make participation as seamless and successful as possible. In order to make sure that our program is compatible with your support needs, we would like to provide you with more detailed information about our program considerations. In addition, to make sure that the City can safely and meaningfully accommodate the needs, we are requesting additional information from you and the treating physician. We would also like to further explain the steps and process for designing an accommodation to best meet your support needs, in consideration of safety and available Department resources.

## PRCR Program Considerations

The Raleigh Parks, Recreation and Cultural Resources Department boasts more than 200 parks including features like amusements, art centers, athletic facilities, community centers, lakes, nature preserves, off-leash dog parks, playgrounds, swimming pools, historic homes, and open spaces. PRCR programs occur throughout all parks and facilities, on our greenways, and at non-City locations. The City cannot control environmental conditions at activities conducted off-site. Participants should plan accordingly and must notify staff in advance if alternative activities would be safer or more appropriate.

**Program Activities & Requirements:** Programs have various activities such as free choice play, active activities in a large room/gym/outdoors, passive/quiet activities, arts and crafts, recreational sports, games, field trips, food and food experiences, and specialty programs. Programs may involve a high level of gross motor skills and physical mobility/activity including climbing, balancing, stopping, kneeling, crouching, crawling, jumping/hopping, standing, walking, running, and physical contact between participants. Programs may involve a high level of fine motor skills as appropriate for the specific program content. In addition, participants should exhibit a moderate level of expressive and receptive communication skills and a moderate level of appropriate social skills, such as turn taking and peer cooperation.

**Program Environment & Spaces:** Programs may be held in a variety of spaces such as a room inside a community/art/etc. center, outdoor tennis/basketball/volleyball court, baseball/softball/open field, playground, picnic shelter, gymnasium (with or without air-conditioning), pool, etc. There may be multiple transitions between various spaces, environments and activities during the program. Some programs travel to various field trip locations, some greater than 50 miles away from the base program location. For trips, transportation may be provided by PRCR vehicles or by a charter bus. Participants may be exposed to a variety of indoor spaces both air conditioned and not air conditioned, and outdoor spaces in different weather conditions and temperatures. There are specific activities and spaces that will be loud (music, shouting, etc.) and some activities that will be in dim lighting (movies, video games, etc.).



**Staffing:** All programs operate under the direction of a full-time staff that provides oversight and support to the program and instructors/staff. Some programs are instructed directly by full-time staff, while others are instructed by part-time staff. Staffing ratios and plans are unique and individualized per program. All program instructors are trained in City policies and procedures, and at least one staff with the program/facility is certified in First Aid and CPR. While there will be at least one or two staff members with First Aid and CPR certification with the program at all times, no staff members are required to have medical training or certifications above First Aid and CPR.

## Needed Information

The Medical Management Plan (MMP) – please work with the treating physician to complete this form in its entirety. It is acceptable for a participant/parent/guardian to fill out the form as long as the physician reviews and signs it. The City will rely on this form in order to make reasonable attempts to make accommodations and provide an opportunity to meaningfully participate in program activities. Because the City has no staff with medical training or experience specific to particular limitations and needs, Parks, Recreation and Cultural Resources staff must rely on the MMP in order to safely supervise the participant. The MMP must be returned to the City at least two weeks before the start of the program. However, in order to allow as much time as possible for development of a support plan, to allocate available resources, and to provide additional training, the City would like to receive the MMP back from you as far in advance as possible. The form is attached to this letter and includes an overview for the physician.

## Next Steps

PRCR staff will review the MMP once it is received to determine whether PRCR resources are adequate to safely accommodate.

- If we are able to accommodate, PRCR staff will contact you and will work with the participant/parent/guardian to develop an appropriate support plan. Medical accommodations are the most successful when we work directly with the treating physician and the participant/parent/guardian to develop the support plan and offer training for the program staff. Effective communication between the City and the participant/parent/guardian will be essential to the development of a care plan that accurately reflects the care needs. After the support plan has been developed, PRCR staff will work with you to verify how staff will implement the procedures.
- We will work collectively to schedule and conduct appropriate training for the staff that will be working to provide support. The City asks that you be available during the training to share with staff any pertinent information, and to partner with any appropriate medical staff to provide information about any equipment or situations that may be unique.

Please let us know as you have questions. We look forward to serving you in our programs!

Sincerely,

Laurel Heizelman, LRT/CTRS, CPRP  
Inclusion Manager  
Specialized Recreation and Inclusion Services  
919-996-2149

Christen Winstead, LRT/CTRS, CPRP  
Program Director  
Specialized Recreation and Inclusion Services  
919-996-2111

# Medical Management Plan (Diabetes)



Dear Physician:

One of your patients has registered to participate in a City of Raleigh Parks, Recreation and Cultural Resources Department program or event, and we have been requested to provide support for care. Please review the program considerations below and discuss the specific program with your patient. Then, please complete the attached Medical Management Plan (MMP) in full. This record will remain in the participant's file so that we may assist with their medical care and needs. The completed MMP will be valid for one calendar year from the date of your signature, unless there are changes in their condition.

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with the program/facility is certified in First Aid and CPR. While there will be at least one or two staff members with First Aid and CPR certification with the program at all times, no staff members are required to have medical training or certifications above First Aid and CPR.

If you have any questions regarding the MMP or more specific program considerations, please contact us.

Sincerely,

Laurel Heizelman, LRT/CTRS, CPRP  
Inclusion Manager  
Specialized Recreation and Inclusion Services  
919-996-2149  
[Laurel.heizelman@raleighnc.gov](mailto:Laurel.heizelman@raleighnc.gov)

Christen Winstead, LRT/CTRS, CPRP  
Program Director  
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# Medical Management Plan (Diabetes)



This plan is designed for participants under the age of 18 or those over the age of 18 who may need support managing their condition. It should be completed by the participant's personal health care team, including the parent/guardian. It should be reviewed with relevant Parks, Recreation and Cultural Resources staff and copies should be kept in a place that can be accessed easily by authorized personnel. This plan is valid for one year from the physician's signature unless condition or care changes.

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

Date of Diagnosis: \_\_\_\_\_ type 1    type 2    Other: \_\_\_\_\_

Program: \_\_\_\_\_ Location: \_\_\_\_\_

Program 2 (if applicable): \_\_\_\_\_ Location: \_\_\_\_\_

Additional Programs and Locations: \_\_\_\_\_

## CONTACT INFORMATION

Guardian:

Address:

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

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

Guardian:

Address:

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

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

Participant's Physician/Health Care Provider:

Address:

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

Phone Number: \_\_\_\_\_

Emergency Number: \_\_\_\_\_

Other Emergency Contact:

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

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

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

This following is a general meal schedule for the City of Raleigh camps. This may differ depending on the program, age of participant, or the weekly schedule. Please confirm with program for more specific times. Please consider these times when deciding when to check blood glucose and when to administer insulin.

**The following may occur between:**

9:00 AM - 10:00 AM: Morning snack

11:30 AM - 12:30 PM: Lunch

2:00 PM - 3:00 PM: Afternoon snack

**CHECKING BLOOD GLUCOSE**

Target range of blood glucose: 70-130 mg/dL      70-180 mg/dL      Other:

Preferred site of testing:    Fingertip      Forearm      Thigh      Other:

**Please indicate when check BG (a row left blank indicates no action is required):**

		When?		Method?	
		__ min. Before*	__ min. After*	Finger Prick	CGM
<b>Routine</b>	AM Snack				
	Lunch				
	PM Snack				
	Physical Activity (playground, gym games, outdoor play, etc)				
	Before Bus Ride				
	After Swimming				
<b>Special Circumstance</b>	Special Food Activity				
	CGM alert				
	Signs/Symptoms of illness				
	Signs/Symptoms of low blood glucose				
	Signs/Symptoms of high blood glucose				
	After a correction dose				

\*Please specify how many minutes before or after

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.

May check blood glucose with supervision.

Requires trained diabetes personnel to check blood glucose .

**Continuous Glucose Monitor (CGM):**    Yes    No

Brand/Model:

Alarms set for:                    mg/dL (low) and                    mg/dL (high)

*Note: If participant has symptoms or signs of hypoglycemia, hyperglycemia, or illness, check fingertip blood glucose level regardless of CGM.*

**HYPOGLYCEMIA TREATMENT**

Participant's usual symptoms of hypoglycemia (list below):

Give a quick-acting glucose product equal to                    grams of carbohydrate if blood glucose level is less than                    mg/dL.

BG determined by:    Finger Prick                    Continuous Glucose Monitor (select one)

Please list quick-acting glucose products that will be provided by the parent/guardian:

Repeat treatment if blood glucose level is less than                    mg/dL after                    minutes of first treatment.

BG determined by:  Finger Prick     Continuous Glucose Monitor (select one)

Additional treatment:

Follow physical activity and sports orders (see page 8).

If the participant is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:

Glucagon:  1 mg     1/2 mg    Route:    Intramuscular    Other:

Site for glucagon injection:  Arm     Thigh     Other:

Call 911 (Emergency Medical Services) and then the participant's parents/guardian.

Contact participant's health care provider.

**HYPERGLYCEMIA TREATMENT**

Participant's usual symptoms of hyperglycemia (list below):

Check for ketones when blood glucose levels are greater than      mg/dL, every      hours.

BG determined by:      Finger Prick      Continuous Glucose Monitor

Check for ketones by:      Blood      Urine

Additional treatment for ketones:

Give correction dose of insulin\* when blood glucose levels are greater than      mg/dL  
AND at least      hours since last insulin dose

BG determined by:      Finger Prick      Continuous Glucose Monitor

Parents/guardian authorization should be obtained before administering a  
correction dose      Yes      No

*\*For insulin pump users: see additional information for participant with insulin pump (pg. 5).*

Give extra water and/or non-sugar-containing drinks (not fruit juices):      ounces per  
hour.

Follow physical activity and sports orders (see page 8).

- Notify parents/guardian 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 parents/guardian.
- Contact participant's health care provider.

**Please continue onto next page**



**PLEASE CHECK WHICH INSULIN THERAPY IS USED AND THEN CONTINUE TO THAT SPECIFIC PAGE.**

- Insulin pump (continue on this page)  
 Syringe (continue to page 6)  
 Insulin pen (continue to page 6)

Insulin will be administered  BEFORE  AFTER meal (Please select one).

Will snacks need to be covered or are they “free”? Please specify the carbohydrate limit on free snacks, if there is a blood glucose range for free snacks, etc.

**INFORMATION FOR PARTICIPANT WITH INSULIN PUMP**

**General Information:**

Brand/Model of pump:

Type of insulin in pump:

Basal rates during program:

Type of infusion set:

**Participant's self-care pump skills:**

**Independent?**

Count carbohydrates	Yes	No
Bolus correct amount for carbohydrates consumed	Yes	No
Calculate and administer correction bolus	Yes	No
Calculate and set basal profiles	Yes	No
Calculate and set temporary basal rate	Yes	No
Change batteries	Yes	No
Disconnect pump	Yes	No
Troubleshoot alarms and malfunctions Reconnect	Yes	No
pump to infusion set**	Yes	No
Prepare reservoir and tubing**	Yes	No
Insert infusion set**	Yes	No

**Pump Failure:**

For blood glucose greater than \_\_\_\_\_ mg/dL that has not decreased within \_\_\_\_\_ hours after correction, consider pump failure or infusion site failure.

Please indicate how you would like PRCR staff to respond:

Notify parents/guardian

Give insulin by syringe\*

Give insulin by insulin pen\*

\*For pump failure: please complete instructions for carb calculation and correction dose on pages 6 and 7.

\*\*For infusion site failure: If participant is not independent, parent/guardian is responsible for inserting new infusion set and/or replacing reservoir.

**Physical Activity for Insulin Pump Users****Swimming:**

May the pump get wet?    Yes    No

Instructions:

**Water Activities:** (Participant will be dressed in normal day clothes – ie: water play, boating, etc.)

May the pump get wet?    Yes    No

Instructions:

**Other:** Please list other times participant may disconnect from pump (sports activities, specific games, swimming, etc):**If disconnecting:**

Set a temporary basal rate    Yes    No                      % temporary basal for                      hours

**INFORMATION FOR PARTICIPANT WITHOUT PUMP OR FOR PUMP FAILURE****Type of insulin therapy during program:**

- Adjustable Insulin Therapy
- Fixed Insulin Therapy
- No insulin

**Adjustable Insulin Therapy**

Name of insulin:

**Carbohydrate Coverage****Morning Snack (9-10 am):** 1 unit of insulin per                      grams of carbohydrate

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:

**Lunch (11:30 am- 12:30 pm):** 1 unit of insulin per                      grams of carbohydrate

Carbohydrate coverage only

Carbohydrate coverage plus correction dose when blood glucose is greater than  
                    mg/dL and                      hours since last insulin dose.

Other:





**SIGNATURES: PHYSICIAN**

As the treating physician of (participant's name) , I have reviewed the program description, likely environmental conditions, and physical requirements of (program name) . In my judgment, I believe (participant's name) may safely participate in (program name) and that the physical limitations of (participant's name) may be successfully met by non-medical personnel. Therefore, I, (physician) approve this Medical Management Plan and acknowledge that the procedures outlined in this plan may be performed by non- medical personnel.

Participant's Physician/Health Care Provider Name

Participant's Physician/Health Care Provider Signature                      Date

*I intend and agree that typing my name above constitutes my electronic signature, which acknowledges my consent to the terms set forth herein. I intend that my electronic signature have the same legal force and effect as a written signature. I consent to using electronic means by which to provide written authorization for the Medical Management Plan and procedures for the above referenced participant, and further agree that I have provided the written authorization as required by law.*

## Diabetes Management Procedures

**\*To be completed by the parent/guardian.**

I acknowledge that the ability of PRCR staff to successfully implement (participant's name) 's MMP depends on the timeliness and accuracy of the information provided herein. I further acknowledge that PRCR staff will rely upon the information provided herein in order to make reasonable efforts to:

- Provide care consistent with the most current approved MMP.
- Provide accurate, timely information about the scheduled activities and program environment.
- Train staff on all procedures outlined in the MMP who will be responsible for providing care.
- Ensure trained diabetes personnel are with the participant/on-site at all times during the program.
- Train all other staff in the program how to recognize signs/symptoms of high/low blood glucose and to communicate any concerns to trained diabetes personnel.
- Document care provided as it is given using approved documentation.
- Provide adequate space as needed for diabetes care.
- Provide appropriate storage, access, and disposal for diabetes medication and equipment.
- Communicate with the parent/guardian as outlined in the communication protocol.

### **Parent/Guardian will:**

Provide information regarding the most current approved MMP and any future updates or changes to the plan (when possible at least 2 weeks in advance).

Participate in training staff of the Raleigh Parks, Recreation and Cultural

Resources Department as requested to review equipment and/or procedures that are specific to the participant.

Provide adequate meals/snacks with carbohydrate counts clearly labeled.

Provide clear instructions for how program provided meals/snacks should be handled.

Provide all medication and medical equipment needed to implement the approved MMP in the program.

Perform any site changes that may be needed for participants with a CGM/Insulin Pump.

Communicate with Raleigh Parks, Recreation and Cultural Resources as outlined in the communication protocol.

**Medication storage/access:**

The following medications will be provided to the program in accordance with the approved MMP and have the following storage/access requirements:

Medication:

Storage:

- Access:  On-site (access in less than 10 minutes, ie. stored in office)  
 Immediate (medication must be with participant at all times)

Medication:

Storage:

- Access:  On-site (access in less than 10 minutes, ie. stored in office)  
 Immediate (medication must be with participant at all times)

Medication:

Storage:

- Access:  On-site (access in less than 10 minutes, ie. stored in office)  
 Immediate (medication must be with participant at all times)

**Communication protocol:**

I request that Parks, Recreation and Cultural Resources staff contact the parent/guardian immediately in the following circumstances:

Any time the participant's emergency action plan is activated for high or low blood glucose

Any time there is suspected pump failure or infusion site failure

For authorization to give a correction dose

For any circumstance compromising PRCR's ability to provide care

Parks, Recreation and Cultural Resources will contact the parent/guardian:

To discuss special program circumstances that could impact care (examples include field trips, overnights, program provided food)

Parent/Guardian will contact PRCR:

Any time the participant's MMP or management procedures need to be updated

Any time changes in the participant's medical condition could cause care during the program to be problematic

Any time the participant will be absent from the program

Additional information or responsibilities:



**SIGNATURES: PARENT/GUARDIAN**

I, (parent/guardian) \_\_\_\_\_ give permission to the personnel of the City of Raleigh Parks, Recreation and Cultural Resources Department to perform and carry out the care tasks as outlined in (participant's name) \_\_\_\_\_ Medical Management Plan.

I understand and acknowledge that the City of Raleigh is not a healthcare provider, and that this document contains protected health information regarding (participant's name) \_\_\_\_\_. I freely authorize disclosure of this information to the City of Raleigh for the purposes stated herein, and I understand that the information used or disclosed herein may be subject to re-disclosure, and that disclosure of this information may mean that this information is no longer protected by Federal privacy regulations. I expressly consent to the release of the information contained in this Medical Management Plan to all program staff members and other adults who have responsibility for the participant and who may need to know this information to maintain the participant's health and safety. I also give permission to the PRCR staff and/or qualified health care professional to contact the participant's physician/health care provider. I understand that any action already taken in reliance on this authorization cannot be reversed.

Participant's Parent/Guardian Name

Participant's Parent/Guardian Signature

Date

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Acknowledged and received by:

PRCR Authorized Representative

Date