

**Date of Plan:** \_\_\_\_\_

## **Diabetes Medical Management Plan**

*This plan should be completed by the student's personal health care team and parents/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, trained diabetes personnel, and other authorized personnel.*

Effective Dates: \_\_\_\_\_

Student's Name: \_\_\_\_\_

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

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

Physical Condition:  Diabetes type 1       Diabetes type 2

### **Contact Information**

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

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

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

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

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

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

Student's Doctor/Health Care Provider:

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

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

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

Other Emergency Contacts:

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

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

**Notify parents/guardian or emergency contact in the following situations:**

- 1. Loss of consciousness or seizure immediately after calling 911 and administering Glucagon.**
- 2. Blood sugars in excess of \_\_\_\_\_ mg/dl.**
- 3. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.**

**Blood Glucose Monitoring**

Target range for blood glucose is  70-150  70-180  Other \_\_\_\_\_

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

Times to do extra blood glucose checks (*check all that apply*)

- before exercise
- after exercise
- when student exhibits symptoms of hyperglycemia
- when student exhibits symptoms of hypoglycemia
- other (explain): \_\_\_\_\_

Can student perform own blood glucose checks?  Yes  No

Exceptions: \_\_\_\_\_  
\_\_\_\_\_

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

**Insulin**

**Usual Lunchtime Dose**

Base dose of Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting insulin used) is \_\_\_\_\_ units or does flexible dosing using \_\_\_\_\_ units/ \_\_\_\_\_ grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente \_\_\_\_\_ units or basal/Lantus/Ultralente \_\_\_\_\_ units.

**Insulin Correction Doses**

Parental authorization should be obtained before administering a correction dose for high blood glucose levels.  Yes  No

\_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

\_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

\_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

\_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

\_\_\_\_\_ units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

Can student give own injections?  Yes  No

Can student determine correct amount of insulin?  Yes  No

Can student draw correct dose of insulin?  Yes  No

\_\_\_\_\_ Parents are authorized to adjust the insulin dosage under the following circumstances:

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**For Students with Insulin Pumps**

Type of pump: \_\_\_\_\_ Basal rates: \_\_\_\_\_ 12 am to \_\_\_\_\_  
\_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_\_ to \_\_\_\_\_

Type of insulin in pump: \_\_\_\_\_

Type of infusion set: \_\_\_\_\_

Insulin/carbohydrate ratio: \_\_\_\_\_ Correction factor: \_\_\_\_\_

*Student Pump Abilities/Skills:*

*Needs Assistance*

- |                                                 |                              |                             |
|-------------------------------------------------|------------------------------|-----------------------------|
| Count carbohydrates                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bolus correct amount for carbohydrates consumed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and administer corrective bolus       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set basal profiles                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set temporary basal rate          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Disconnect pump                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Reconnect pump at infusion set                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prepare reservoir and tubing                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insert infusion set                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Troubleshoot alarms and malfunctions            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**For Students Taking Oral Diabetes Medications**

Type of medication: \_\_\_\_\_ Timing: \_\_\_\_\_

Other medications: \_\_\_\_\_ Timing: \_\_\_\_\_

**Meals and Snacks Eaten at School**

Is student independent in carbohydrate calculations and management?  Yes  No

| <i>Meal/Snack</i>   | <i>Time</i> | <i>Food content/amount</i> |
|---------------------|-------------|----------------------------|
| Breakfast           | _____       | _____                      |
| Mid-morning snack   | _____       | _____                      |
| Lunch               | _____       | _____                      |
| Mid-afternoon snack | _____       | _____                      |
| Dinner              | _____       | _____                      |

Snack before exercise?  Yes  No

Snack after exercise?  Yes  No

Other times to give snacks and content/amount:

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Preferred snack foods:

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Foods to avoid, if any:

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Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

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### Exercise and Sports

A fast-acting carbohydrate such as \_\_\_\_\_ should be available at the site of exercise or sports.

Restrictions on activity, if any: \_\_\_\_\_ student should not exercise if blood glucose level is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl or if moderate to large urine ketones are present.

**Hypoglycemia (Low Blood Sugar) (below \_\_\_\_\_ mg/dl) \_\_\_\_\_ Never leave student alone!**

**Mild : BG < \_\_\_\_\_**

\_\_\_\_ Give 15 gms glucose; recheck in 10 minutes

\_\_\_\_ If BG <70, retreat and recheck every 10 minutes x 3

\_\_\_\_ Notify parent if not resolved

\_\_\_\_ Provide snack with CHO, fat, protein after treating and meal not scheduled >1 hour

**Severe: Loss of consciousness**

**Or seizure**

\_\_\_\_ Call 911. Open airway.

\_\_\_\_ Turn to side

\_\_\_\_ Glucagon injection \_\_\_\_ mg

\_\_\_\_ Notify parent

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

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

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**Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.**

Route \_\_\_\_\_, Dosage \_\_\_\_\_, site for glucagon injection: \_\_\_\_\_ arm, \_\_\_\_\_ thigh, \_\_\_\_\_ other.

If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

**Hyperglycemia (High Blood Glucose) (Above \_\_\_\_\_ mg/dl)**

\_\_\_\_ Sugar-free fluids/frequent bathroom privileges

\_\_\_\_ If BG is greater than \_\_\_\_\_, initiate insulin orders

\_\_\_\_ If BG is greater than \_\_\_\_\_, check for ketones. Notify parents if ketones are present

\_\_\_\_ May not need snack

\_\_\_\_ Note and document changes in status

\_\_\_\_ Notify parent per "Emergency Notification" Section

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 Kept at School**

\_\_\_\_ Blood glucose meter, blood glucose test strips, batteries for meter

\_\_\_\_ Lancet device, lancets, gloves, etc.

\_\_\_\_ Urine ketone strips

\_\_\_\_ Insulin pump and supplies

\_\_\_\_ Insulin pen, pen needles, insulin cartridges

\_\_\_\_ Fast-acting source of glucose

\_\_\_\_ Carbohydrate containing snack

\_\_\_\_ Glucagon emergency kit

**Self-Administration of Diabetes Medications**

\_\_\_\_ I have instructed and monitored \_\_\_\_\_ (student's name) on insulin injections, self checking blood sugar levels, and self managing low and high blood sugar levels. It is my professional opinion that he/she should be allowed to carry and perform self care in the classroom or any location at school.

\_\_\_\_ It is in my professional opinion that \_\_\_\_\_ (student's name) should **NOT** be allowed to carry his/her own diabetic supplies including insulin or syringes, or self-administer insulin without the assistance of the school nurse or unlicensed diabetes care personnel.

\_\_\_\_\_  
Student's Physician/Health Care Provider

\_\_\_\_\_  
Date

**SAN ANGELO INDEPENDENT SCHOOL DISTRICT**  
**Authorization for Administration of Diabetes Management and Care**  
**Services**  
**By Unlicensed Diabetes Care Assistant**

**Information to Parents:** The health and safety of each student is always of paramount importance to every San Angelo ISD employee. The District is committed to providing a high level of care to meet any special medical needs students exhibit. To help carry out that commitment, San Angelo ISD ensures that a Registered Nurse is assigned to each campus. The 79<sup>th</sup> Texas Legislature, through House Bill 984, amended that Health and Safety Code to provide more specific requirements for the provision of diabetes management and care services to students in public schools who seek care for the student's diabetes while at school. The school, in conjunction with the parent, will develop for each student who seeks care for diabetes at school an Individualized Health Plan that will specify the diabetes management and care services the student requires at school. Traditionally, the school nurse has provided any medical care students might require at school. Under HB 984, each school also must train other employees to serve as Unlicensed Diabetes Care Assistants who can provide diabetes management and care services if a nurse is not available when a student needs such services. Such services include the administration of insulin or, in an emergency, glucagons. San Angelo ISD has trained staff at each school to provide such services. HB 984 further specifies that an Unlicensed Diabetes Care Assistant exercises his or her judgment and discretion in providing diabetes care services and that nothing in the statute limits the immunity from liability afforded to employees under section 22.0511 of the Texas Education Code.

Under HB 984, an Unlicensed Diabetes Care Assistant may only administer diabetes care and management services if the student's parent/guardian authorizes an Unlicensed Diabetes Care Assistant to assist the student and confirms his or her understanding that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

**Please check the appropriate boxes below to indicate your election whether to allow: 1. an Unlicensed Diabetes Care Assistant to provide services to your child; 2. self-care; 3. disclosure of your child's condition:**

**YES, Agreement for Services:** I authorize an Unlicensed Diabetes Care Assistant to provide diabetes management and care services to my child at school. I understand that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

**NO, I DO NOT** authorize an Unlicensed Diabetes Care Assistant to provide diabetes management and care services to my child at school.

**YES,** My child can manage his/her diabetes independently and will not seek assistance for his/her diabetes while at school. I understand the school nurse will provide emergency care as needed. This information will be shared with school district personnel as needed.

**YES**, I request that my child's classmates be informed that my child has diabetes, and given age-appropriate instruction regarding diabetes care, so that they understand the importance of symptoms and the types of intervention that may occur in the classroom.

\_\_\_\_\_  
Student Name (please print)

\_\_\_\_\_  
School

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date Signed

I also give permission to the school nurse to share this information with the appropriate school personnel.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date