# Diabetes Packet

## ** New forms are required at the beginning of every school year.

Please note:

- We also accept your endocrine office's version of a Diabetes Medical Management Plan. It should cover the same information outlined in the district plan.
- Please submit this prior to the first day of school so that staff can be properly trained with the specifics outlined in the plan prior to students returning to the classroom.

# Diabetes Medical Management Plan (DMMP) Confidential

**Student Name: _____**

**DOB: _____**

| | | |
|---|---|---|
| **Name:** | **DOB:** | **Grade:** |
| **Parent/Guardian:** | **Phone #:** | **School:** |
| **MD/Endocrinologist:** | **Phone #** | **fax#** |

**Medical Diagnosis:** Diabetes Type 1 or Type 2 (please circle one)

Diabetic History:

- ❏ Age of diagnosis:_____Routine Management Target Blood Glucose Range _____ to _____

**Emergency Notification**

**Notify parents of the following conditions.**

- ❏ Loss of Consciousness or seizure (convulsion)* Call parent immediately after Glucagon given & 911 called
- ❏ Blood sugars over_____mg/dl
- ❏ Moderate to large Urine Ketones
- ❏ Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing or altered level of consciousness
- ❏ Other:_____

***If unable to reach parent/guardian call emergency contact number:_____**

## Blood Glucose Monitoring:

Continuous Glucose Monitoring ☐ Yes ☐ No details: _____

Blood Glucose Monitoring: ☐ Yes ☐ No Meter:_____

If yes, can student perform own blood glucose checks? ☐ Yes ☐ No Needs Supervision: ☐ Yes ☐ No

Student Interprets results: ☐ Yes ☐ No Document result and send copy home weekly ☐ Yes ☐ No

Times to be performed: ☐ Before Breakfast ☐ Before PE/Activity_____

☐ Mid-morning:before snack ☐ After PE/Activity _____

☐ Before Lunch ☐ Mid-afternoon _____

☐ Dismissal ☐ As needed for signs/symptoms of low/high blood glucose

Place to be performed: ☐ Classroom ☐ Clinic/ Health Room ☐ Other _____

**Call parent if blood glucose values are below_____or above_____.**

## Insulin/Medications at School:

**Insulin Injections during school:** ☐ Yes ☐ No

If Yes: Can Student -Determine correct dose? ☐ Yes ☐ No Draw Up own dose? ☐ Yes ☐ No

-Give own injections? ☐ Yes ☐ No Need Supervision? ☐ Yes ☐ No

Insulin Delivery: ☐ Pen ☐ Pre-Drawn syringe ☐ Syringe/via ☐ Pump

*for dosing see insulin dosing guidelines

**For Students with Insulin Pumps:**

**Type of pump: _____ Basal Rates: _____ from _____ to _____**

**_____ from _____ to _____**

**_____ from _____ to _____**

**Type of insulin in pump:_____**

**Type of infusion set: _____**

**Insulin/Carbohydrate ratio: _____ Correction Factor:_____**

| Student Pump Abilities/ Skills | Needs Assistance (circle) | |
|---|---|---|
| Count Carbohydrates..... | yes | no |
| Bolus Correct amount for carbohydrates consumed ..... | yes | no |
| Calculate and administer corrective bolus..... | yes | no |
| Calculate and set temporary basal rate..... | yes | no |
| Disconnect pump..... | yes | no |
| Reconnect pump at infusion set..... | yes | no |
| Prepare reservoir and tubing..... | yes | no |
| Insert infusion set..... | yes | no |
| Trouble shoot alarms and malfunctions..... | yes | no |

**Other routine Diabetes medications at school:** ☐ Yes ☐ No

| Name of Medication: | Dose: | Time: | Route: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Sliding Scale: Blood Glucose Correction and Insulin Doseage using (Rapid Acting) Insulin:**

Blood Glucose Range_____mg/dl Administer _____units

Blood Glucose Range_____mg/dl Administer _____units

Blood Glucose Range_____mg/dl Administer _____units

Blood Glucose Range_____mg/dl Administer _____units and check ketones

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Insulin to Carbohydrate Ratio_____ unit(s) for every _____grams of carbohydrates(or to be) eaten

- Parent/guardian authorized to increase or decrease sliding scale +/-2 units of insulin.
- Parent/guardian authorized to increase or decrease insulin to carbohydrate count with the following range: 1 unit per prescribed grams of carbohydrates +/-5 grams of carbohydrates.

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## Meals and Snacks Eaten at School:

**Meals/Snacks: 1 Carb serving= 15 grams of carbohydrates**

□ Student can independently count carbohydrates

□ Needs assistance with carbohydrate counting for snacks and meals

### Morning & Snack Plan

| | □ Carb servings or<br>□ Carbohydrate Grams eaten at meal or snack | |
|---|---|---|
| **Meal/ Snack** | Amount: | **Time:** |
| Breakfast | | |
| Mid-morning snack | | |
| Lunch | | |
| Mid-afternoon snack | | |

In addition to the above meal plan the student may require an extra snack:

□ Before gym □ after gym □ only when needed

Location where snacks are kept:_____

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 physical activity: _____

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):**

Usual symptoms of hypoglycemia: _____

_____

Treatment of hypoglycemia: _____

_____

Glucagon administration:

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

Route:_____ Dosage:_____ Site:_____

If glucagon is required, administer it promptly. Then call 911 and the guardian/ parents.

**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:_____

_____

_____

**Diabetes Care Supplies:**

While in school or at school- sponsored activities, the student is required to have available the following diabetic supplies (check all that apply):

- ☐ Blood Glucose Meter, test strips, batteries for meter
- ☐ Lancet Device, lancets
- ☐ Insulin Pen, pen needles, insulin cartridges, syringes
- ☐ Urine Ketone Strips
- ☐ Fast-Acting source of glucose
- ☐ Insulin Pump and Supplies
- ☐ Carbohydrate containing snack
- ☐ Glucagon Emergency Kit
- ☐ Bottled Water
- ☐ Other (Please Specify) _____

The school district will supply gloves for caregivers and a sharps box

## PHYSICIAN CONSENT FOR DIABETES MANAGEMENT DMMP

I have reviewed and approved the Diabetes Management IHP and have included any recommended modification. I understand that specialized physical health care services for Diabetic Medical Management Plan will be performed by trained personnel. This consent is for a maximum of one year.

This school plan will expire on:_____

Practitioner Name (Print):_____

Practitioner Signature: _____ Date:_____

**Signatures:**

As parent/guardian of the above named student, I give permission to the school nurse and other designated staff to perform and carry out the diabetes tasks outlined in the Individualized Health Plan (IHP) and for my child's healthcare provider to share information with the school health coordinator for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any changes in the student's health status or care. Parents/Guardian and student are responsible for maintaining necessary supplies, snack, blood glucose monitor, medications and equipment.

Student's Signature:_____ Date:_____

Parent/Guardian SIgnature:_____Date:_____

School Nurse Or Designee: Signature:_____ Date: _____

This document follows guidelines and principles outlined by the American Diabetes Association.