SCHOOL DIABETES MEDICAL MANAGEMENT PLAN School _____ Grade ____ School Fax _____

Student _____ **DOB** _____ ***Effective for one year - beginning date*** _____

Blood Glucose Monitoring
- ▫ before lunch ▫ before snack ▫ before boarding bus
- ▫ after school activities

AND all suspected hypoglycemia

Meal Plan Carbohydrate amount per parent/guardian
- ▫ a.m. snack ▫ lunch ▫ p.m. snack ▫ mandatory
- Extra food allowed at: ▫ parent's discretion ▫ student's discretion

(For treatment of hypo/hyperglycemia see decision tree on back of form)

Hypoglycemia Treatment Guidelines BG <_____mg/dl
- ▫ Self treatment of mild lows ▫ Assistance for all lows
- ☒ Immediately treat with 15 gm fast-acting carbohydrate- e.g. 4 oz juice, 3-4 glucose tabs, 3 tsp glucose gel (cakemate)
- ☒ Recheck BG in 15 minutes and repeat above until BG > 80
- ☒ If more than 1 hour until meal give 15 gm Carb snack – (e.g. cheese and crackers, half a sandwich)

Severe Hypoglycemia unconscious, seizure, unable to swallow
- ☒ Inject **Glucagon** dosage _____ mg
- ☒ Lay student on side to prevent aspiration
- ☒ C**all 911** ☒ Notify parent/guardian

Hyperglycemia Treatment Guidelines BG >_____mg/dl
- ▫ If insulin therapy by **injection**: check ketones when BG > 250 **and** symptoms of ketosis (e.g. headache, stomach ache, nausea/vomiting)
- ▫ Insulin by **pump:** check ketones whenever BG > 250

Ketone testing: ▫ blood ketones ▫ urine ketones
- ☒ If **moderate/large urine ketones/ > 0.6 mmol blood ketones –** Notify parents. Student to go home. No vigorous activity.
- ☒ If negative, trace or small ketones – Give student water, access to the bathroom and student may return to usual activity.

Insulin Orders ▫ Humalog ▫ Novolog ▫ Apidra
- ▫ No insulin at school at this time

a. ▫ Insulin delivery **injection** ▫ syringe and vial ▫ pen
- Time: ▫ a.m. snack ▫ lunch ▫ p.m. snack
- Meal bolus: ____ units of insulin per ____ grams of carbohydrate

Correction scale at **Lunch**

Blood Glucose Value	**/ Units of Insulin**
< 100 =	_____ units
100 to 150 =	_____ units
151 to 200 =	_____ units
201 to 250 =	_____ units
251 to 300 =	_____ units
301 to 350 =	_____ units
351 to 400 =	_____ units
> 400 =	_____ units

For after school correction scale see current Diabetes Clinic Visit Summary.

b. ▫ Insulin delivery **pump** – with ALL carb intake, (snack and lunch) Use current pump setting for meal and correction bolus.

P.E. Guidelines
- ☒ Carbohydrate food/beverage must be available before, during and after exercise (to treat and or prevent low blood sugar)
- ☒ Eat 15 grams carbohydrate (no insulin bolus) before vigorous activity/exercise- e.g. running laps, etc.

Field trips and after school activities
- ☒ Arrange for appropriate monitoring and access to supplies

MANAGEMENT PLAN REVIEWED BY

_____
(School Nurse/Personnel name/title) **(date)**

DISASTER PREPAREDNESS PLAN

Parents to provide the following supplies

☒ 1 vial/pen of: ▫ Rapid-acting insulin _____ ▫ Basal insulin _____

☒ syringes/pen needles ☒ test strips/meter ☒ Glucagon kit ☒ 15 gram fast-acting carbohydrate source ▫ pump supplies (extra battery)

In case of emergency (food not available):

▫ 6 p.m.: Basal Insulin – Give ____ unit(s) of _____

▫ 8 a.m. and 6 p.m.: Rapid-acting Insulin correction scale - Give_____ unit(s) _____insulin for every _____ mg/dl >_____ mg/dl

▫ Insulin pump- continue regimen. If pump fails give correction dose by injection **every 3 hours** _____ insulin : ___ unit per ___ mg/dl> ____

PHYSICIAN AUTHORIZATION AND INSTRUCTIONS FOR DIABETES MANAGEMENT IN SCHOOL

My signature provides authorization for the written orders specified above. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that unlicensed school employees, who have received appropriate training by a school nurse or other health care professional with experience in diabetes, may perform specialized physical health care services. This authorization is for a maximum of one year.

Student has been instructed in the proper way to: ▫ check blood glucose ▫ administer insulin

It is my professional opinion that student should be allowed to:
- ▫ carry meter ▫ check blood glucose ▫ independently ▫ with supervision
- ▫ carry insulin ▫ administer insulin ▫ independently ▫ with supervision (dose verification)
- ▫ cannot self-check blood glucose ▫ cannot self-administer insulin

MD Name _____ **Signature** _____ **Date** _____

MD Phone _____ **MD FAX** _____

PARENT/GUARDIAN CONSENT FOR DIABETES MANAGEMENT IN SCHOOL

I, the undersigned, request that the following specialized physical health care services for the management of diabetes in school to assist my child in accordance with th
Education Code 49423. I will:

1. Provide the necessary supplies and equipment (including a copy of operating instructions)
2. Notify school Nurse/Personnel if there is a change in my child's health status or attending physician.
3. Notify the school Nurse/Personnel immediately and provide a copy of the Diabetes Clinic Visit Summary for any regimen changes.

I authorize the school Nurse/Personnel to communicate with my child's diabetes medical team when necessary. I understand that I will be provided a copy of my child
completed Individual Health Care Plan (IHCP) or Section 504 Plan.

Parent/Guardian Signature _____ **Phone**_____ **Date** _____

Revised 04/11