DIABETES MEDICAL MANAGEMENT PLAN (School Year _____-_____)

Student's Name: _____ Date of Birth: _____ Diabetes ☐Type 1 ; ☐Type 2 Date of Diagnosis :_____

School Name: _____ Grade _____ Homeroom _____ Plan Effective Date(s) :_____

CONTACT INFORMATION

Parent/Guardian #1: _____ Phone Numbers: Home _____ Work_____ Cell/Pager _____

Parent/Guardian #2: _____ Phone Numbers: Home_____ Work_____ Cell/Pager _____

Diabetes Healthcare Provider_____ Phone Number;_____

Other Emergency Contact_____ Relationship:_____ Phone Number: Home _____ Work/Cel/Pager_____

EMERGENCY NOTIFICATION: Notify parents of the following conditions (*If unable to reach parents, call Diabetes Healthcare Provider listed above)*

a. Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.
b. Blood sugars in excess of_____ mg/dl
c. Positive urine ketones.
d. Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, or altered level of consciousness.

MEALS/SNACKS: Student can: ☐ Determine correct portions and number of carbohydrate serving ☐ Calculate carbohydrate grams accurately

	Time/Location	Food Content and Amount		Time/Location	Food Content and Amount
☐ Breakfast			☐ Mid-afternoon		
☐ Midmorning			☐ Before PE/Activity		
☐ Lunch			☐ After PE/Activity		

If outside food for party or food sampling provided to class:_____

BLOOD GLUCOSE MONITORING AT SCHOOL: ☐ Yes ☐ No Type of Meter: _____

If yes, can student ordinarily perform own blood glucose checks? ☐Yes ☐No; Interpret results ☐Yes ☐No; Needs supervision? ☐Yes ☐No

Time to be performed:
- ☐ Before breakfast
- ☐ **M**idmorning: before snack
- ☐ Before lunch
- ☐ Dismissal
- ☐ Before PE/Activity Time
- ☐ After PE/Activity Time
- ☐ Mid-afternoon
- ☐ As needed for signs/symptoms of low/high blood glucose

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

OPTIONAL: *Target Range for blood glucose: _____mg/dl to _____mg/dl (Completed by Diabetes Healthcare Provider).*

INSULIN INJECTIONS DURING SCHOOL: ☐ Yes ☐ No ☐ Parent/Guardian elects to give insulin needed at school)

If yes, can student: Determine correct dose? ☐Yes ☐No Draw up correct dose? ☐Yes ☐No

Give own injection? ☐Yes ☐No Needs supervision? ☐Yes ☐No

Insulin Delivery: ☐ Syringe/Vial ☐ Pen ☐ Pump (If pump worn, use "Supplemental Information Sheet for Student Wearing an Insulin Pump")

Standard daily insulin <u>at school</u>: ☐ Yes ☐ No

Type:	**Dose:**	**Time to be given**:

Calculate insulin dose for carbohydrate intake: ☐Yes ☐No

If yes, use**:** ☐Regular ☐Humalog ☐Novolog

_____# unit(s) per_____ grams Carbohydrate

☐ Add carbohydrate dose to correction dose

***<u>Correction Dose of Insulin for High Blood Glucose</u>*:** ☐Yes ☐No

If yes: ☐Regular ☐Humalog ☐Novolog Time to be given: _____

☐ *Determine dose per sliding scale below (in units):*

Blood sugar:_____ Insulin Dose:_____
Blood sugar:_____ Insulin Dose: _____
Blood sugar:_____ Insulin Dose: _____
Blood sugar:_____ Insulin Dose: _____
Blood sugar:_____ Insulin Dose: _____

☐ *Use formula:*

(Blood glucose – _____) ÷ _____ =

units of insulin

OTHER ROUTINE DIABETES MEDICATIONS AT SCHOOL: ☐Yes ☐ No

Name of Medication	Dose	Time	Route	Possible Side Effects

EXERCISE, SPORTS, AND FIELD TRIPS

Blood glucose monitoring and snacks as above. Quick access to sugar-free liquids, fast-acting carbohydrates, snacks, and monitoring equipment.

A fast-acting carbohydrate such as _____ should be available at the site.

Child should not exercise if blood glucose level is below _____mg/dl **OR** if _____

SUPPLIES TO BE FURNISHED/RESTOCKED BY PARENT/GUARDIAN: (Agreed-upon locations noted on emergency card/nursing care plan)

- ☐ Blood glucose meter/strips/lancets/lancing device
- ☐ Ketone testing strips
- ☐ Sharps container for classroom
- ☐ Fast-acting carbohydrate_____
- ☐ Carbohydrate-containing snacks
- ☐ Carbohydrate free beverage/snack
- ☐ Insuln vials/syringe
- ☐ Insulin pen/pen needles/cartridges
- ☐ Glucagon Emergency Kit

MANAGEMENT OF HIGH BLOOD GLUCOSE (over_____mg/dl)

✓Usual signs/symptoms for this student:
- ☐ Increased thirst, urination, appetite
- ☐ Tiredness/sleepiness
- ☐ Blurred vision
- ☐ Warm, dry, or flushed skin
- ☐ Other _____

Indicate treatment choices:
- ☐ Sugar-free fluids as tolerated
- ☐ Check urine ketones if blood glucose over _____mg/dl
- ☐ Notify parent if urine ketones positive.
- ☐ May not need snack***: call parent***
- ☐ See "**Insulin Injections: Correction Dose of Insulin for High Blood Glucose"**
- ☐ Other _____

MANAGEMENT OF VERY HIGH BLOOD GLUCOSE (over _____ mg/dl)

✓Usual signs/symptoms for this student
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Rapid, shallow breathing
- ☐ Extreme thirst
- ☐ Weakness/muscle aches
- ☐ Fruity breath odor
- ☐ Other _____

Indicate treatment choices:
- ☐ Carbohydrate-free fluids if tolerated
- ☐ Chcck urine for ketones
- ☐ Notify parents per **"Emergency Notification" section**
- ☐ If unable to reach parents, call diabetes care provider
- ☐ Frequent bathroom privileges
- ☐ Stay with student and document changes in status
- ☐ Delay exercise.
- ☐ Other_____

MANAGEMENT OF LOW BLOOD GLUCOSE (below _____mg/dl)

✓Usual signs/symptoms for this child
- ☐ Hunger
- ☐ Change in personality/behavior
- ☐ Paleness
- ☐ Weakness/shakiness
- ☐ Tiredness/sleepiness
- ☐ Dizziness/staggering
- ☐ Headache
- ☐ Rapid heartbeat
- ☐ Nausea/loss of appetite
- ☐ Clamminess/sweating
- ☐ Blurred vision
- ☐ Inattention/confusion
- ☐ Slurred speech
- ☐ Loss of consciousness
- ☐ Seizure
- ☐ Other_____

Indicate treatment choices:

If student is awake and able to swallow,
give _____*grams fast-acting carbohydrate such as:*
- ☐ 4oz. Fruit juice or non-diet soda *or*
- ☐ 3-4 glucose tablets *or*
- ☐ Concentrated gel or tube frosting *or*
- ☐ 8 oz. Milk *or*
- ☐ Other_____

Retest BG 10-15minutes after treatment
Repeat treatment until blood glucose over 80mg/dl
Follow treatment with snack of _____
if more than 1 hour till next meal/snack or if going to activity
☐ Other _____

IMPORTANT!!

<u>If student is unconscious or having a seizure</u>, presume the student is having a low blood glucose and:

Call 911 immediately and notify parents.

- ☐ **Glucagon ½ mg or 1 mg (circle desired dose) should be given by trained personnel.**
- ☐ **Glucose gel 1 tube can be administered inside cheek and massaged from outside while awaiting or during administration of Glucagon by staff member at scene.**
- ☐ **Glucagon/Glucose gel could be used if student has documented low blood sugar and is vomiting or unable to swallow.**

Student should be turned on his/her side and maintained in this "recovery" position till fully awake".

SIGNATURES

I/we understand that all treatments and procedures may be performed by the student and/or trained unlicensed assistive personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed this information sheet and agree with the indicated instructions. This form will assist the school health personnel in developing a nursing care plan.

Parent's Signature: _____ Date: _____

Physician's Signature_____ Date: _____

School Nurse's Signature: _____ Date: _____

This document follows the guiding principles outlined by the American Diabetes Association

Revised December 5, 2003