DIABETES MEDICAL MANAGEMENT PLAN

Student's Name: _____ Medical Record #: _____ Date of Birth: _____

BLOOD GLUCOSE MONITORING

Student routinely checks blood glucose prior to insulin administration at meal time. Student may check blood glucose as needed throughout the school day.

INSULIN DOSING

Type of insulin: Novolog or Humalog or Apidra
INSULIN PUMP: FOLLOW INSULIN DOSE PER PUMP DIRECTIONS ☐
Meal time insulin dose to be given pre-meal unless alternative checked: ☐ post-meal ☐ either pre- or post-meal

Before school meal	*Lunch*	*After school meal*
Insulin dose = _____ units Insulin dose = _____ units/_____ grams of carbohydrates	Insulin dose = _____ units Insulin dose = _____ units/_____ grams of carbohydrates	Insulin dose = _____ units Insulin dose = _____ units/_____ grams of carbohydrates
Sliding Scale: (DO NOT USE IF WITHIN 3 HOURS OF PREVIOUS INSULIN DOSE).		
___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 ___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 ___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 ___units if blood glucose is _____ to _____ mg/dl ___units if blood glucose is _____ to _____ mg/dl ___units if blood glucose is _____ to _____ mg/dl
Sliding scale is based on correction factor of ____units/_____ mg/dl blood sugar.	*Sliding scale is based on correction factor of ____units/_____ mg/dl blood sugar.*	*Sliding scale is based on correction factor of ____units/_____ mg/dl blood sugar.*

☐ Use this dose if insulin is used to cover snacks: Insulin dose = _____ units/____ grams carb.
☐ Do not use insulin to cover snacks.
☐ OK to use Dexcom G6 readings to dose insulin.

School Nurse (licensed RN) may <u>decrease</u> total insulin dosage.

Student's Level of Independence:

Student can perform own blood glucose checks	☐ No	☐ With Supervision	☐ Yes
Student can calculate carbohydrates independently	☐ No	☐ With Supervision	☐ Yes
Student can determine correct amount of insulin	☐ No	☐ With Supervision	☐ Yes
Student can draw correct dose of insulin	☐ No	☐ With Supervision	☐ Yes
Student can give own injections	☐ No	☐ With Supervision	☐ Yes
Student can bolus correctly (for carbohydrates or for correction of hyperglycemia)	☐ No	☐ With Supervision	☐ Yes
Student can troubleshoot alarms and malfunctions on pump	☐ No	☐ Yes	
Student may carry own diabetic supplies (ie; pen/glucometer)	☐ No	☐ Yes	
Student uses a Continuous Glucose Monitor (CGM) which may require cellphone use		☐ No	☐ Yes

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HYPOGLYCEMIA (Low Blood Sugar)

If conscious and able to swallow:

If blood glucose is < 80 mg/dl, give 15 grams of carbohydrates and recheck blood glucose in 15 minutes. Repeat until blood glucose is > 80mg/dl.

If unconscious or having seizure, give Glucagon injection IM:

- ☐ 0.5 mg
- ☐ 1.0 mg

If Glucagon is indicated, administer it simultaneously while calling 911 and the parents/guardians.

HYPERGLYCEMIA (High Blood Sugar)

- ☐ Check urine ketones if blood glucose > 350 mg/dl.
- ☐ Give insulin per orders (**For students on injections, DO NOT USE WITHIN 3 HOURS OF PREVIOUS INSULIN DOSE; For students on pumps, follow pump's directions for dose**).

  ❖ *IF KETONES are MODERATE or LARGE and student has symptoms, student <u>will be sent home</u>.*

GUIDELINES FOR PE and/or EXERCISE

- ☐ If blood glucose is between 80-120 mg/dl before exercise, provide 15 grams of carbohydrates and allow child to participate.
- ☐ OK to disconnect pump for up to ___ hour(s) for exercise.

PHYSICIAN'S AUTHORIZATION
FOR DIABETES MEDICAL MANAGEMENT PLAN

My signature below provides authorization for this Diabetes Medical Management Plan. I understand that in some school districts specialized health care services may be observed by unlicensed designated school personnel under the training provided by a school nurse or RN**. This authorization is for the current school year. If changes are indicated, I will provide new written authorization.**

Physician's Name (Print): _____

Physician's Signature: _____ **Date:** _____

Kaiser   **Sutter**   **UC Davis Medical Center**   **Other:** _____

Physician's Telephone: (   ) _____ **Physician's Fax: (   )** _____

Parent's Name (Print): _____ **Telephone: (   )** ____-_____

Parent/Guardian Signature: _____ **Date:** _____