

Student Name: _____

School Year: _____



School-based Medical Management Plan for the Student with Diabetes Mellitus

To be completed by Parent/Guardian

Name: _____ Birthdate: _____ Grade: _____

Address: _____

Mother/Guardian: _____ Phone: (home) _____ (cell) _____

Father/Guardian: _____ Phone: (home) _____ (cell) _____

Other Emergency Contact: _____ Phone: _____ Relationship: _____

Symptoms: (check student's usual symptoms)

Hypoglycemia (low blood sugar)	Hyperglycemia (high blood sugar)
<input type="checkbox"/> Shaky <input type="checkbox"/> Weak <input type="checkbox"/> Sweaty <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Dizzy <input type="checkbox"/> Pale <input type="checkbox"/> Headache <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Tiredness <input type="checkbox"/> Hungry <input type="checkbox"/> Confusion <input type="checkbox"/> Seizure <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Irritability/Personality changes <input type="checkbox"/> Other _____	<input type="checkbox"/> Increased thirst <input type="checkbox"/> Increased urination <input type="checkbox"/> Tiredness <input type="checkbox"/> Increased appetite <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Headache <input type="checkbox"/> Sweet, fruity breath <input type="checkbox"/> Dry, itchy skin <input type="checkbox"/> Achiness <input type="checkbox"/> Stomach pain/nausea/vomiting <input type="checkbox"/> Seizure <input type="checkbox"/> Loss of consciousness/coma <input type="checkbox"/> Other _____

To be completed by Diabetes Team

Physical Condition: Diabetes Type 1 Diabetes Type 2 Date of Diagnosis: _____

SECTION I - Routine Management

Blood Sugar (Glucose) Testing

Preferred testing location: Classroom Office Where convenient

Test prior to Breakfast Snack Lunch Before PE After PE Before leaving school

Test when symptomatic

Student can perform own glucose test: No Yes, Independently Supervised

Record glucose reading and send home to parent/guardian weekly

- ❖ If child's blood sugar is low (< _____), refer to Section II, Low Blood Glucose Reading (Hypoglycemia)
- ❖ If child's blood sugar is high (> _____), refer to Section III, High Blood Glucose Reading (Hyperglycemia)

Insulin Administration

Type of Insulin: _____

Preferred administration location: Classroom Office Where convenient

SQ (Use I:C card/chart) PUMP (All settings programmed into pump)

Prior to Breakfast

Immediately after Breakfast

Prior to Lunch

Immediately after Lunch

Prior to Snack

Immediately after Snack

Student can calculate insulin dosage: No Yes, Independently Supervised

Student can self-administer insulin: No Yes, Independently Supervised

Parent/Guardian **MAY** transmit changes of therapy, including insulin doses, to school personnel in writing

Student Name:

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SECTION II - Responding to Low Blood Glucose (BG) Reading (Hypoglycemia)

Preferred testing location: Classroom Office Where convenient

Hypoglycemia level for age: Under 5 years of age = BG < 90 or 90-110 with symptoms
 5-11 years of age = BG < 80 or 80-100 with symptoms
 12 years and older = BG < 70 or 70-90 with symptoms

Treat with **15 grams** of quick carb (4 oz. juice or 3-4 glucose tabs): Treat with **30 grams** of quick carb (8 oz. juice or 6-8 glucose tabs):

- | | |
|---|--|
| <input type="checkbox"/> Under 5 years, BG < 90 or 90-110 with symptoms | <input type="checkbox"/> Under 5 years, BG < 60 |
| <input type="checkbox"/> 5-11 years, BG < 80 or 80-100 with symptoms | <input type="checkbox"/> 5-11 years, BG < 55 |
| <input type="checkbox"/> 12 years and older, BG < 70 or 70-90 with symptoms | <input type="checkbox"/> 12 years and older, BG < 50 |

Recheck BG and treat every 15 minutes until BG is above hypoglycemic level for age

Severe Low Blood Glucose: Student is unconscious, having a seizure, or having difficulty swallowing

- Stay with student, protect from injury, turn on side
 - Do not put anything into the student's mouth
 - Appoint someone to call 911 and the family
 - Suspend or remove insulin pump (if worn)
 - Give Glucagon: 5-30 lbs, Give 0.3cc or 30 units 31-50 lbs, Give 0.5 cc or 50 units 51 + lbs, Give 1.0 cc or 100 units
- 1.) Inject liquid from syringe into vial to dilute powder
 - 2.) Draw appropriate amount of Glucagon into the syringe
 - 3.) Inject Glucagon into student's upper arm or upper leg muscle
 - 4.) Turn student on side

SECTION III - Responding to High Blood Glucose (BG) Reading (Hyperglycemia)

For BG of ____ - 300: If not meal time - no intervention, return to class

If meal time, give extra insulin at: Breakfast Lunch Snack (Use insulin correction factor card/chart)

For BG of 300+: Have student check ketones when strips are available

Positive Ketones: Call parent/guardian Give 8-16 oz. of water hourly No exercise, gym, or recess
 If on pump, check infusion set Recheck ketones at next urination

Negative Ketones: If not meal time - no intervention, return to class

If meal time, give extra insulin at: Breakfast Lunch Snack (Use insulin correction factor card/chart)

If no ketone strips are available: Treat as Positive Ketones (and request strips from family)

SECTION IV - Food and Misc.

- Snack daily at _____ Snack as needed for low blood sugar Never withhold food
 - Never withhold access to water or bathroom Have 15 grams of quick carb available at site physical activity
- For special occasions that involve food: always contact parent for guidance **OR** student can self-manage
- When out of classroom, student will always travel with buddy
 - For fieldtrips, always group student with trained school staff member or own parent

Parent/Guardian Signature

Date

Physician Signature

Date

(Void if not signed)

Information transcribed from _____ by _____ on _____
(Oordering Physician or Agency) (RN, Physician, or PA) (Date)