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 Numbers home _____ Work/Cell/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: D Determine correct portions and number of carbohydrate serving D 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
- □ Midmorning: before snack
- □ Before breakfast
- □ 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 _____(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 Correction dose of insulin for high blood sugar: ☐ Yes ☐ No

If yes, use: ☐ Regular ☐ Humalog ☐ Novolog If yes: ☐ Regular ☐Humalog ☐Novolog Time to be given_____

_____# unit(s) per _____grams Carbohydrate **Use Formula: (BG-_____) / _____ = Units of insulin**

□Add carbohydrate dose to correction dose If student uses a sliding scale please attach to DMMP.

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 ☐ Fast-acting carbohydrate _____ ☐ Insulin vials/syringe

☐ Ketone testing strips ☐ Carbohydrate-containing snacks ☐ Insulin pen/pen needles/cartridges

☐ Sharps container for classroom ☐ Carbohydrate free beverage/snack ☐ Glucagon Emergency Kit

504 TESTING PERAMATERS:

Blood Glucose should be between _____ and _____ for school tests.

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_____ mg/dl
- ☐ Check urine ketones if blood glucose over
- ☐ 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
- ☐ Check 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 10-15minut.es 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!!

If student is unconscious or having a seizure*, presume the student is having a low blood glucose and:*

Call 911 immediately and notify parents.

- ☐ Glucagon 1/2 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