_____ County School District Health Services

DIABETES MEDICAL MANAGEMENT PLAN

STUDENT/CONTACT INFORMATION

Student Name:	DOB:	Diabetes Type:	Date Diagnosed:
School Year: _____- _____	Effective Date : _____	School:	Grade:
Parent/Guardian #1:	Primary #:	Secondary #:	Email:
Parent/Guardian #2:	Primary #	Secondary #:	Email:
Other Emergency Contact:	Primary #	Secondary #:	Relationship:
Diabetes Healthcare Provider:		Phone #:	Fax #:

DIABETES MONITORING AT SCHOOL

Blood Glucose **Range** _____to_____	**Ketones:** ☐**Urine** ☐**Blood** ☐**N/A**	**Continuous Glucose Monitoring:** ☐**N/A**
☐ Check Before Breakfast	☐ Check ketones If blood glucose over _____ mg/dL.	Brand: ____
☐ Check Before Mid-AM Snack		High Glucose Alert Setting: ____ mg/dL
☐ Check Before Lunch		Low Glucose Alert Setting: ____ mg/dL
☐ Check Before Afternoon Snack	☐ Check ketones for complaints of abdominal pain, nausea/vomiting.	**CONFIRM CGM SENSOR GLUCOSE WITH BG CHECK BEFORE CORRECTIVE ACTION.**
☐ Check Before Physical Activity	☐ Other times to check ketones: ____	
☐ Check After Physical Activity		
☐ Check Before Dismissal	*Note: Normal blood ketones below 0.6mmol/L*	Check BG for signs/symptoms of high/ow glucose regardless of CGM value.
☐ Check if S/S of High/Low Blood Glucose		
☐ Other Blood Glucose Check:	☐ **Notify parent if ketones _____*(to pick up child if urine ketones mod-lg or blood ketones > 1mmol/L).**	**Notify parent if CGM site painful, draining/ bleeding, inflamed, irritated**.*
☐ **Notify parent if BG over ____mg/dL***		

Delay exercise if: Blood glucose is below ____, over ____, ketones _____, or _____.

**Diabetes Healthcare Provider will be contacted if unable to reach parent within 30 minutes.*

DIABETES MEDICATION AT SCHOOL

Insulin Delivery Method: ☐n/a ☐ Pen ☐ Syringe/Vial ☐ Pump – Brand/Model: _____

Rapid-Acting Insulin Brand: ☐ Humalog ☐ Novolog ☐ Apidra ☐ May substitute brand if needed

Fixed Rapid-Acting Insulin Dose to be given with meals: ☐n/a ☐ Add Correction below

☐ **Fixed Meal Scale (Meal + High BG Dose) Times: _____**		☐ **Correction Only Scale Times: _____**		☐ **Correction Only Formula (Instead of Scale) Times: _____**
If blood glucose:	*Insulin Dose*	*If blood glucose:*	*Insulin Dose*	Target BG = _____mg/dL
_____ to _____	give _____ units	_____ to _____	give _____ units	Correction (Sensitivity) Factor _____mg/dL
_____ to _____	give _____ units	_____ to _____	give _____ units	(Blood Glucose-Target BG) ÷ Correction Factor = # units to correct high BG. i.e., (Current BG - _____) ÷ _____=_____units
_____ to _____	give _____ units	_____ to _____	give _____ units	
_____ to _____	give _____ units	_____ to _____	give _____ units	☐ Give correction dose if over ___ hours since last dose &/carbohydrate intake
_____ to _____	give _____units	_____ to _____	give _____ units	☐ Add correction dose to Flexible Carb Coverage per "Meals/Snacks" below.
_____ to _____	give _____ units	_____ to _____	give _____ units	☐Round to nearest ☐0.5 ☐1 unit
_____ to "HI"	give _____ units	_____ to "HI"	give _____ units	☐ Always round fraction down.

Other Insulin(s) to be taken at school (Type/Dose/Time) ☐n/a_____

Parent can adjust insulin dose as follows: ☐n/a_____

Other routine diabetes medication(s) to be taken at school: ☐n/a (Type/Dose/Time)_____

Student Name:_____

MEALS/SNACKS				
Meal/Snack	**Time**	**Carbohydrate Target** ☐ As desired	**Flexible Carb Coverage (Insulin : Carb Ratio +/- Correction)**	
☐ Breakfast		_____ grams	☐ 1 unit: _____grams	☐ Add Correction
☐ MidAM Snack		_____ grams	☐ 1 unit: _____grams	☐ Add Correction
☐ Lunch		_____ grams	☐ 1 unit: _____grams	☐ Add Correction
☐ MidAftn Snack		_____ grams	☐ 1 unit:_____grams	☐ Add Correction
☐ Before/After Physical Activity _____		_____ grams	☐ 1 unit:_____grams	☐ Add Correction
☐ Other:____		_____ grams	☐ 1 unit:_____grams	☐ Add Correction
☐Meal/snack should be timed at least ____ hours after last meal/snack if BG to be checked.			☐Pre-meal insulin can be given after meal based on pre-meal BG if student's carbohydrate intake is unpredictable.	

HIGH BLOOD GLUCOSE (HYPERGLYCEMIA) MANAGEMENT

Student's Usual Signs and Symptoms (Mark all that apply):

High Blood Glucose: (Over ____mg/dL)	☐ Increased thirst and/or urination	☐ Hunger	☐ Headache	☐ Fatigue/ drowsiness	☐ Dry skin	☐ Weakness/ muscle aches	☐ Blurred vision
Very High Blood Glucose: (Over ____mg/dL)	☐ Nausea/vomiting/ abdominal pain	☐ Dizziness	☐ Extreme thirst	☐ Fruity breath odor	☐ Altered breathing	☐ Other:	

High Blood Glucose Treatment:

☐ See correction insulin instructions under "Diabetes Medications at School" on pg. 1.
☐ Check "Ketones" (see Diabetes *Monitoring*).
☐ If urine ketones are negative to trace (blood 0-1mmol/L) without symptoms, give insulin correction dose (see *Diabetes Medications*), give ____oz. sugar-free fluid/hour, and send back to class with frequent bathroom privileges.
☐ Re-check blood glucose in ____ minutes if previous blood sugar was over ____ mg/dL.
☐ Delay next meal/snack until blood glucose is below ____mg/dL if previous blood sugar was over ____ mg/dL.
☐ If urine ketones are moderate to large (blood over 1 mmol/L) notify parent and call diabetes healthcare provider for insulin dose instructions. Give sugar-free liquids/water if not vomiting and stay with student.
☐ Call parent if high blood glucose accompanied by symptoms of illness.
Child to go home for moderate to large ketones (blood ketones over 1mmol/L or high blood glucose with symptoms of illness.

LOW BLOOD GLUCOSE (HYPOGLYCEMIA) MANAGMENT

Low Blood Glucose = Blood Glucose below ____mg/dL ☐Not applicable

Student's Usual Signs and Symptoms (Mark all that apply):

☐Shakiness	☐Sweating	☐Paleness	☐Rapid Heartbeat	☐Numbness/ Tingling	☐Irritability/ Mood Change	☐Fatigue
☐ Headache	☐ Inattention/ Confusion	☐ Slurred Speech	☐Poor Coordination	☐Seizure	☐Loss of consciousness	☐ Other:____

Low Blood Glucose Treatment:

*If student is awake and able to swallow/control airway, g*ive __, grams fast-acting carbohydrate- e.g
__ oz. fruit juice __ glucose tablets __ oz. regular soda __ oz. low fat milk __15gm tube glucose gel
Re-check blood glucose every 15 minutes and re-treat until blood glucose is over ____ .

Treat with 15 grams of solid carbohydrate once blood sugar is over ____ mg/dL.

If student has severe hypoglycemia (is unresponsive/having seizure/unable to control airway): Call 911 or send another to do so.
☐ Trained personnel to give Glucagon/Glucagen subq/IM - ☐ ½mg ☐1mg ☐ Give 15gm tube glucose gel
☐ Contact parent/guardian if glucagon/gel given for severe hypoglycemia or if low blood glucose treatment is ineffective. Call diabetes healthcare provider if unable to reach parent within 20 minutes.

ADDITIONAL CONSIDERATIONS FOR STUDENT WITH AN INSULIN PUMP

☐ If blood glucose over ____ mg/dL ____times in a row or any bG over ____ check ketones. Follow high blood glucose instructions **BUT** give correction dose with syringe or pen and have student change infusion set. Notify parent if assistance needed.
☐ Inspect pump site, tubing/pod in event of alarms, high blood glucose, or student complains of pain at infusion site. Contact parent if pump site dislodged or leaking.
☐ If student experiences severe hypoglycemia, suspend/remove pump or cut tubing. Send non-disposables with EMS to hospital.

Student Name:_____

ADDITIONAL TIMES TO NOTIFY PARENT/GUARDIAN/PROVIDER

- ☐ Student refusing medication.
- ☐ Unusual reaction to any diabetes medication.
- ☐ Correction dose given after ____pm.
- ☐ Student unavoidably detained at school.
- ☐ Other: ____.

SUPPLIES TO BE FURNISHED BY PARENT TO SCHOOL

☐ BG strips, meter, lancets, lancing device	☐ Snacks: carb and carb-free	☐ Insulin pen/ cartridges, pen needles	☐ Glucagon/ Glucagen	☐ Pump Infusion Sets/Pods	☐ Spare batteries Meter/pump/CGM
☐ Ketone strips +/- meter	☐ Juice, glucose tabs/ gel or regular soda	☐ Insulin vial/syringe	☐ Other prescribed diabetes med	☐ Pump reservoirs / cartridges	☐ Other: ____

DISASTER PLAN

In case student's normal diabetes management routine and support is disrupted by unexpected emergency:

Re-unite student as soon as safely possible with diabetes supplies/emergency kit and trained caregiver/parent.

Keep student as well-hydrated as possible and keep rapid-acting carbohydrate with student.

☐ Use correction only scale every 3 hours (if at least 3 hours since last insulin/carb intake).

Switch to rapid acting insulin injections if pump/site fails and unable to restart.

☐ Use insulin:carb ratio + correction formula every 3+ hours.

☐ Student able to self-manage during disaster conditions unless incapacitated.

Contact parent/diabetes team for additional instructions.

DIABETES SELF-CARE ASSESSMENT

Task	N/A	Needs Assistance	Needs Supervision	Independent (requires no help/supervision for routine care, can carry meds/supplies)
Performs and Interprets Blood Glucose Checks	☐	☐	☐	☐
Calculates Carbohydrate Grams	☐	☐	☐	☐
Determines Correction Dose of Insulin for High Blood Glucose	☐	☐	☐	☐
Determines Insulin Dose for Carbohydrate Intake	☐	☐	☐	☐
Administers Insulin by pump or injection	☐	☐	☐	☐
Troubleshoots alarms and malfunctions if using insulin pump	☐	☐	☐	☐
Disconnects/reconnects pump if needed	☐	☐	☐	☐
Programs pump basal rates/sets temporary rates if needed	☐	☐	☐	☐
Changes insulin pump infusion site if needed	☐	☐	☐	☐
Responds to CGM alarms	☐	☐	☐	☐

SIGNATURES/PARENTAL CONSENT

This Diabetes Medical Management Plan has been approved by:

OFFICE STAMP HERE

Diabetes Healthcare Provider Signature:_____

Date:_____

I (parent/guardian) 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 medical management plan and agree with the indicated instructions. This form will assist the school health personnel in developing a nursing care plan.

I consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety.

I also give permission to the school nurse or authorized school personnel to contact my child's diabetes healthcare provider when necessary.

Parent Signature:_____ Date:_____

School RN:_____ Date:_____