

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)

- Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.
- Blood sugars in excess of _____ mg/dl
- Positive urine ketones.
- 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
<input type="checkbox"/>	Breakfast	_____	<input type="checkbox"/>	Mid-afternoon	_____
<input type="checkbox"/>	Midmorning	_____	<input type="checkbox"/>	Before PE/Activity	_____
<input type="checkbox"/>	Lunch	_____	<input type="checkbox"/>	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 Before PE/Activity Time
 Midmorning: before snack After PE/Activity Time
 Before lunch Mid-afternoon
 Dismissal 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 at school: Yes No

Type:	Dose:	Time to be given:
_____	_____	_____
_____	_____	_____

Correction Dose of Insulin for High Blood Glucose: Yes No

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

<i>Use formula:</i>	
<i>Determine dose per sliding scale below (in units):</i>	<i>(Blood glucose 4 _____) ÷ _____ = _____ units of insulin</i>
Blood sugar: _____ Insulin Dose: _____	
Blood sugar: _____ Insulin Dose: _____	
Blood sugar: _____ Insulin Dose: _____	
Blood sugar: _____ Insulin Dose: _____	

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

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)

- | | | |
|--|---|---|
| <input type="checkbox"/> Blood glucose meter/strips/lancets/lancing device | <input type="checkbox"/> Fast-acting carbohydrate _____ | <input type="checkbox"/> Insulin vials/syringe |
| <input type="checkbox"/> Ketone testing strips | <input type="checkbox"/> Carbohydrate-containing snacks | <input type="checkbox"/> Insulin pen/pen needles/cartridges |
| <input type="checkbox"/> Sharps container for classroom | <input type="checkbox"/> Carbohydrate free beverage/snack | <input type="checkbox"/> Glucagon Emergency Kit |

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

DUsual signs/symptoms for this student:

- œ Increased thirst, urination, appetite
- œ Tiredness/sleepiness
- œ Blurred vision
- œ Warm, dry, or flushed skin
- œ Other _____

Indicate treatment choices:

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

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

DUsual signs/symptoms for this student

- œ Nausea/vomiting
- œ Abdominal pain
- œ Rapid, shallow breathing
- œ Extreme thirst
- œ Weakness/muscle aches
- œ Fruity breath odor
- œ Other _____

Indicate treatment choices:

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

MANAGEMENT OF LOW BLOOD GLUCOSE (below _____ mg/dl)

DUsual signs/symptoms for this child

- œ Hunger
- œ Change in personality/behavior
- œ Paleness
- œ Weakness/shakiness
- œ Tiredness/sleepiness
- œ Dizziness/staggering
- œ Headache
- œ Rapid heartbeat
- œ Nausea/loss of appetite
- œ Clamminess/sweating
- œ Blurred vision
- œ Inattention/confusion
- œ Slurred speech
- œ Loss of consciousness
- œ Seizure
- œ Other _____

Indicate treatment choices:

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

- œ **Glucagon ½ mg or 1 mg (circle desired dose) should be given by trained personnel.**
- œ **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.**
- œ **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

DIABETES MEDICAL MANAGEMENT PLAN SUPPLEMENT FOR STUDENT WEARING INSULIN PUMP
School Year _____ - _____

Student Name: _____ Date of Birth: _____ Pump Brand/Model: _____
 Pump Resource Person: _____ Phone/Beeper _____ (See basic diabetes plan for parent phone#)
 Child-Lock On? Yes No How long has student worn an insulin pump? _____
 Blood Glucose Target Range: _____ - _____ Pump Insulin: Humalog Novolog Regular
 Insulin: Carbohydrate Ratios: _____
 (Student to receive carbohydrate bolus *immediately before* / _____ minutes before eating)
 Lunch/Snack Boluses Pre-programmed? Yes No Times _____
 Insulin Correction Formula for Blood Glucose Over Target: _____
 Extra pump supplies furnished by parent/guardian: infusion sets reservoirs batteries dressings/tape insulin syringes/insulin pen

STUDENT PUMP SKILLS	NEEDS HELP?	IF YES, TO BE ASSISTED BY AND COMMENTS:
1. Independently count carbohydrates	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Give correct bolus for carbohydrates consumed.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Calculate and administer correction bolus.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Recognize signs/symptoms of site infection.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Calculate and set a temporary basal rate.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Disconnect pump if needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Reconnect pump at infusion set.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Prepare reservoir and tubing.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Insert new infusion set.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Give injection with syringe or pen, if needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Troubleshoot alarms and malfunctions.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Re-program basal profiles if needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No	

MANAGEMENT OF HIGH BLOOD GLUCOSE *Follow instructions in basic diabetes medical management plan, but in addition:*

If blood glucose over target range _____ hours after last bolus or carbohydrate intake, student should receive a correction bolus of insulin using formula; Blood glucose - _____ ÷ _____ = _____ units insulin

If blood glucose over 250, check urine ketones

- If no ketones**, give bolus by pump and recheck in 2 hours.
- If ketones present or _____**, give correction bolus as an **injection** immediately and contact parent/ health care provider

If two consecutive blood glucose readings over 250 (2 hrs or more after first bolus given)

- Check urine ketones
- Give correction bolus as an injection
- Change infusion set.
- Call parent

MANAGEMENT OF LOW BLOOD GLUCOSE *Follow instructions in Basic Diabetes Care Plan, but in addition:*

If low blood glucose recurs without explanation, notify parent/diabetes provider for potential instructions to suspend pump.

If seizure or unresponsiveness occurs:

- Call 911 (or designate another individual to do so).
- Treat with Glucagon (See basic Diabetes Medical Management Plan)
- Stop insulin pump by:
 - Placing in "suspend" or stop mode (See attached copy of manufacturer's instructions)
 - Disconnecting at pigtail or clip (Send pump with EMS to hospital.)
 - Cutting tubing
- Notify parent
- If pump was removed, send with EMS to hospital.

ADDITIONAL TIMES TO CONTACT PARENT

- | | |
|---|--|
| <input type="checkbox"/> Soreness or redness at infusion site | <input type="checkbox"/> Insulin injection given |
| <input type="checkbox"/> Detachment of dressing/infusion set out of place | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Leakage of insulin | _____ |

Effective Date(s) of Pump plan: _____

Parent's Signature: _____ Date: _____

School Nurse's Signature: _____ Date: _____

Diabetes Care Provider Signature: _____ Date: _____