DIABETES MELLITUS MEDICAL MANAGEMENT PLAN

School Year: _____

Student's Name: _____Date of Birth: _____

BLOOD GLUCOSE (BG) MONITORING: (Treat BG below _____ mg/dl or above _____mg/dl as outlined below.)
☐ Before meals ☐ as needed for suspected low/high BG ☐2 hours after correction ☐Midmorning ☐Mid-afternoon
INSULIN ADMINISTRATION: Dose determined by: ❑ Student ❑ Parent ❑ School nurse or Trained Diabetes Personnel
Insulin delivery system: ❑ Syringe ❑ Pen ❑ Pump
MEAL INSULIN: (It is best if given right **before eating**. For small children, can give within 15-30 minutes of the first bite of food-or right after meal)
Insulin Type: Humalog Novolog Apidra

☐Insulin to Carbohydrate Ratio: ☐Set Doses: Give _____ units
· Breakfast: **1** unit per _____ grams carbohydrate • Eat _____ grams of carbohydrate
· Lunch: **1** unit per _____ grams carbohydrate
CORRECTION INSULIN: (For high blood sugar. Add before meal insulin to correction/ sliding scale insulin for total meal time insulin dose.)
☐Use the following correction formula (for pre lunch blood sugar over _____):
(BG - ____) ÷ ____ = extra units insulin to provide

☐Sliding Scale:
BG from ____ to ____ = _____ u
BG from ____ to ____ = _____ u
BG from ____ to ____ = _____ u
BG from ____ to ____ = _____ u
> ____ = _____ u

MILD low sugar: Alert and cooperative student (BG below
☐ Never leave student alone
☐ Give 15 grams glucose; recheck in 15 minutes
☐ If BG remains below 70, retreat and recheck in 15 minutes
☐ Notify parent if not resolved
☐ If no meal is scheduled in the next hour, provide an additional snack with carbohydrate, fat, protein.
SEVERE low sugar: Loss of consciousness or seizure
☐Call 911. Open airway. Turn to side.
☐ Glucagon injection ❑ 0.25 mg ❑ 0.50 mg ❑ 1.0 mg IM/SQ
☐ Notify parent.
☐ For students using insulin pump, stop pump by placing in "suspend" or stop mode, disconnecting at pigtail or clip, and/or removing an attached pump. If pump was removed, send with EMS to hospital.

MANAGEMENT OF HIGH BLOOD GLUCOSE (above _____ mg/dl)
☐ Sugar-free fluids/frequent bathroom privileges.
☐ If BG is greater than 300 and it's been 2 hours since last dose, give ❑ HALF ❑ FULL correction formula noted above.
☐ If BG is greater than 300, and it's been 4 hours since last dose, give FULL correction formula noted above.
☐ If BG is greater than ____ check for ketones. Notify parent if ketones are present.
☐ Note and document changes in status.
☐ Child should be allowed to stay in school unless vomiting and moderate or large ketones are present.
MANAGEMENT DURING PHYSICAL ACTIVITY:
Student shall have easy access to fast-acting carbohydrates, snacks, and blood glucose monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below 70 mg/dl or above 300 mg/dl and urine contains moderate or large ketones.
☐Check blood sugar right before physical education to determine need for additional snack.
☐If BG is less than 70 mg/dl, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.
☐Student may disconnect insulin pump for 1 hour or decrease basal rate by _____.
☐At the beginning of a new activity check blood sugar before and after exercise only until a pattern for management is established.
☐A snack is required prior to participation in physical education.
MEAL PLAN:
☐A snack will be provided each day at: _____
☐If regularly scheduled meal plan is disrupted: call parent for care instructions
SPECIAL MANAGEMENT OF INSULIN PUMP:
☐ Contact Parent in event of: ▪ pump alarms or malfunctions ▪ detachment of dressing / infusion set out of place ▪ Leakage of insulin ▪ Student must give insulin injection ▪ Student has to change site ▪ Soreness or redness at site ▪ Corrective measures do not return blood glucose to target range within ___ hrs.
☐ Parents will provide extra supplies including infusion sets, reservoirs, batteries, pump insulin, and syringes.

Student's Name: _____ Date of Birth: _____

This student requires assistance by the School Nurse or Trained Diabetes Personnel with the following aspects of diabetes management:

- ☐ Monitor and record blood glucose levels
- ☐ Respond to elevated or low blood glucose levels
- ☐ Administer glucagon when required
- ☐ Administer insulin or oral medication
- ☐ Monitor blood or urine ketones
- ☐ Follow instructions regarding meals and snacks
- ☐ Follow instructions as related to physical activity
- ☐ Insulin pump management: administer insulin, inspect infusion site, contact parent for problems
- ☐ Provide other specified assistance:

_____

This student may independently perform the following aspects of diabetes management:

Monitor blood glucose:

- ❑ in the classroom
- ❑ in the designated clinic office
- ❑ in any area of the school and at any school related activity

- ❑ Monitor urine or blood ketones
- ❑ Administer insulin
- ❑ Treat hypoglycemia (low blood sugar)
- ❑ Treat hyperglycemia (elevated blood sugar)
- ❑ Carry supplies for blood glucose monitoring
- ❑ Carry supplies for insulin administration
- ❑ Determine own snack/meal content
- ❑ Manage insulin pump
- ❑ Replace insulin pump infusion set

LOCATION OF SUPPLIES/EQUIPMENT: (To be completed by school personnel and parent. Parent to provide and restock snacks and low blood sugar supplies box.)

	Clinic room	With student		Clinic room	With student
Blood glucose equipment	❑	❑	Glucagon kit	❑	❑
Insulin administration supplies	❑	❑	Glucose gel	❑	❑
Keystone supplies	❑	❑	Juice / low blood glucose snacks	❑	❑

EMERGENCY NOTIFICATION: Notify parents of the following conditions:

a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon.
b. Blood sugars in excess of 300 mg/dl, when ketones present.
c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Other emergency contact: _____ Phone #: _____ Relationship: _____

Insurance Carrier: _____ Preferred Hospital: _____

SIGNATURES: I understand that all treatments and procedures may be performed by the student and/or Trained Diabetes 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 give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by school.

PARENT SIGNATURE: _____ DATE: _____

SCHOOL ADMINISTRATOR SIGNATURE: _____ DATE: _____

My signature provides authorization for the above Diabetes Mellitus Medical Management Plan. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

☐ *Student is due for medical appointment for review of diabetes management plan.*

HEALTHCARE PROVIDER SIGNATURE: _____ Date: _____

Diabetes Care Provider: _____

Address: _____