

**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

	<b>Time/Location</b>	<b>Food Content and Amount</b>		<b>Time/Location</b>	<b>Food Content and Amount</b>
<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: \_\_\_\_\_

<input type="checkbox"/> Determine dose per sliding scale below (in units):	<input type="checkbox"/> Use formula:
Blood sugar: _____ Insulin Dose: _____	(Blood glucose – _____) ÷
Blood sugar: _____ Insulin Dose: _____	_____ =
Blood sugar: _____ Insulin Dose: _____	units of insulin
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)**

✓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
- Check urine ketones if blood glucose over \_\_\_\_\_ mg/dl
- 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 10-15minutes 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

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 ½ 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*

**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: \_\_\_\_\_