

Diabetes Medical Management Plan for School Year 2022-23

STUDENT NAME:		DOB:	
Emergency Contact #1	Parent's Name:	Emergency Contact #2	Parent's Name:
	Relationship:		Relationship:
	Home Phone:		Home Phone:
	Work Phone:		Work Phone:
	Cell Phone:		Cell Phone:
Health Care Provider:		Office Contact Person:	
Office Phone:		Office FAX:	
Diagnosis: DIABETES <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2			
MONITORING (Physician Fill Out)			
Target blood sugar range: 70 mg/dl – 120 mg/dl or 80 mg/dl – 150 mg/dl			
<p style="text-align: center;"><u>BLOOD SUGAR MONITORING</u></p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<input type="checkbox"/> Before meals <input type="checkbox"/> For symptoms of hypo/hyperglycemia & anytime student does not feel well <input type="checkbox"/> Before gym/activity <input type="checkbox"/> After gym/activity <input type="checkbox"/> Before dismissal <input type="checkbox"/> Other _____	<input type="checkbox"/> Student requires assistance <input type="checkbox"/> Student requires supervision <input type="checkbox"/> Student is independent <input type="checkbox"/> Permission to self-carry Where performed: <input type="checkbox"/> Clinic <input type="checkbox"/> Classroom <input type="checkbox"/> Other _____	
Notify parent/guardian if blood sugar is ↑ 250 mg/dl or ↓ 50 mg/dl			
<u>KETONE TESTING:</u> Check ketones if blood sugar is ↑ 250 mg/dl. Also when student is ill or complains of nausea /vomiting/abdominal pain. See Page 3			
<i>Notify parent/guardian if ketones are moderate or large. Notify physician if ketones are moderate or large.</i>			
<i>OUT-OF-RANGE BLOOD MANAGEMENT:</i> General guidelines for treating hyperglycemia and hypoglycemia will be followed according to the attached decision trees unless other instructions are specifically detailed by the health Care Provider.			
LOW BLOOD SUGAR (HYPOGLYCEMIA) UNDER 70 mg/dl or 80 mg/dl		HIGH BLOOD SUGAR (HYPERGLYCEMIA) OVER 250 mg/dl	
<ul style="list-style-type: none"> ✓ Check blood sugar ✓ Give 15 grams of fast-acting carbohydrate if blood sugar is ↓70 mg/dl or ____ mg/dl and if the student is conscious and able to swallow. ✓ DOUBLE the amount of carbohydrates to 30 grams if blood sugar is ↓ 50. ✓ Examples of 15 grams of fast-acting carb. * 4 oz. juice * 3-4 glucose tablets ✓ Retest blood sugar 15 minutes after treating ✓ Repeat treatment if needed until blood sugar is ↑ target blood sugar goal. 		<ul style="list-style-type: none"> ✓ Check blood sugar ✓ Check for ketons ✓ Have student drink 6-8 oz. of non-carb liquid every hour ✓ Notify parents and physician if ketones are <i>moderate</i> or <i>large</i> 	

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<i>MEDICATION / INSULIN</i> (Physician Fill Out)		
Insulin to be given during school hours: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> May calculate/give own injections with supervision <input type="checkbox"/> Requires assistance to calculate injections <input type="checkbox"/> Independently calculates own injections	
Insulin to be given by: <input type="checkbox"/> Syringe and Vial <input type="checkbox"/> Pen <input type="checkbox"/> Pump (If by pump, see “Insulin Pumps Supplement”)		
Injection sites to be used: <input type="checkbox"/> Abdomen <input type="checkbox"/> Legs <input type="checkbox"/> Arms <input type="checkbox"/> Hips (all does to be administered subcutaneously)		
Rapid-acting Insulin Type: <input type="checkbox"/> Humalog <input type="checkbox"/> Novolog <input type="checkbox"/> Apidra		
<input type="checkbox"/> INSULIN PER FIXED DOSE: Name of Insulin: Time: @ Mealtimes Dose:		
<input type="checkbox"/> INSULIN PER PUMP CALCULATIONS: see Pump Supplement		
<input type="checkbox"/> INSULIN USING CARBOHYDRATE COUNTING: 1 unit of _____ insulin per _____ grams of carbohydrate	<input type="checkbox"/> With meals <input type="checkbox"/> With snacks if over _____ grams of carbohydrate	
CORRECTION FOR HIGH BLOOD SUGARS <input type="checkbox"/> at mealtimes unless otherwise notified by physician		
<input type="checkbox"/> Correction per <i>“formula”</i> : <div style="text-align: center; margin-top: 20px;"> Blood Sugar - _____ ÷ _____ = units of insulin needed </div>	OR	<input type="checkbox"/> Correction per <i>“sliding scale”</i> : Blood sugar: _____ Units: _____ Blood sugar: _____ Units: _____ Blood sugar: _____ Units: _____ Blood sugar: _____ Units: _____ Blood sugar: _____ Units: _____ Blood sugar: _____ Units: _____ Blood sugar: _____ Units: _____ Blood sugar: _____ Units: _____
<i>MEALS / SNACKS</i> (Physician Fill Out) 1 CARBOHYDRATE SERVING (1 CARB CHOICE) = 15 GRAMS CARBOHYDRATE (= 1 starch = 1 fruit = 1 milk)		
Can student calculate carbohydrate grams/choices accurately? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Food	Time	# CARB GRAMS /CHOICES
Breakfast		
Morning Snack?		
Lunch		
Afternoon Snack?		
Before gym/activity?		
<i>EXERCISE, SPORTS, TRANSPORTATION</i> (Physician Fill Out)		
<input type="checkbox"/> Blood sugar monitoring and snacks as above (generally 15 grams per every 45-60 minutes of exercise)		
<input type="checkbox"/> Provide access to carb-free liquids, fast-acting carbs, snacks, and monitoring equipment.		
Student should NOT exercise:		
- If blood sugar is \uparrow 250 mg/dl and/or has moderate to large ketones.		
- If blood sugar is \downarrow 70 mg/dl or \downarrow 80 mg/dl. Treat for hypoglycemia		
No exercise until blood sugar is above 70 mg/dl or 80 mg/dl.		
<input type="checkbox"/> Inform gym teacher/coach of student’s diabetes.		
<input type="checkbox"/> Inform Transportation of diabetes if student rides bus.		

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GLUCAGON EMERGENCY INJECTION (Physician Fill Out)

If student is unconscious or having a seizure, assume it is a low blood sugar reaction. Call 911 immediately and notify parents.

- Glucagon injection** (circle dose) $\frac{1}{2}$ mg or 1 mg should be given SQ or IM by trained personnel.
- Following injection, turn student on side until fully awake. When alert enough to swallow, give fast-acting carbohydrate as listed above.**

ITEMS TO BE FURNISHED BY PARENTS IMMEDIATELY UPON REQUEST

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Blood glucose meter/strips/lancets/lancing device <input type="checkbox"/> Insulin vials, syringes, pens, needles, cartridges, etc. <input type="checkbox"/> Ketone testing strips <input type="checkbox"/> Fast-acting carbohydrate foods for lows <input type="checkbox"/> Oral medication for diabetes if ordered | <ul style="list-style-type: none"> <input type="checkbox"/> Carbohydrate free beverages/water bottles for highs <input type="checkbox"/> Glucagon Emergency Kit <input type="checkbox"/> Routine daily snacks if ordered <input type="checkbox"/> Glucose tablets <input type="checkbox"/> Diabetes paperwork and updated orders |
|---|---|

STATEMENT OF RESPONSIBILITY (Parent Read)

Parents/Guardians are responsible to:

- Notify school personnel of all changes in their child's medical management plan.
- Give permission for the school nurse to consult with student's Health Care Provider when necessary.
- Provide an adequate amount of all necessary diabetes supplies for student at all times.
- Provide current information on how to be contacted if necessary due to student's medical needs.
- Designate a knowledgeable person who will be available to be contacted, and who will be responsible for the student if the school is unable to contact parents/guardians.
- Make sure that the medical management plan is updated at least yearly and that the school has a copy.

School Personnel are responsible to:

- Follow medical management plan as outlined above while student is at school.
- Notify parents/guardians of any required treatment for low and/or high blood sugars.
- Provide copies of blood sugar logs and care given to parents and Health Care Providers upon request.
- Notify parents/guardians when supplies need replenished.

If a Diabetes Medical Management Plan for the current school year is not provided to the school, the most recent plan available will be followed until the school receives an updated one.

***Signatures:** The following have read and agree to adhere to the above plan (and pump supplement if using pump.) Parents agree to give permission to the school nurse, trained diabetes personnel, and other designated school staff members to perform and carry out the diabetes care tasks as outlined by the student's Diabetes Medical Management Plan. Parents also consent to the release of the information contained in this Diabetes Medical Management Plan, including child's photo to all staff members and other adults who have custodial care of the child and who may need to know this information to maintain the child's health and safety.*

Health Care Provider:	Date
Parent/Guardian:	Date
Student:	Date
School Nurse:	Date