

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 Numbers home _____ Work/Cell/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 breakfast 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 _____ (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: _____

Calculate insulin dose for carbohydrate intake: Yes No Correction dose of insulin for high blood sugar: Yes No

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

_____ # unit(s) per _____ grams Carbohydrate **Use Formula: (BG- _____) / _____ = Units of insulin**

Add carbohydrate dose to correction dose If student uses a sliding scale please attach to DMMP.

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)

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

504 TESTING PERAMATERS:

Blood Glucose should be between _____ and _____ for school tests.

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

<p>Usual signs/symptoms for this student:</p> <input type="checkbox"/> Increased thirst, urination, appetite <input type="checkbox"/> Tiredness/sleepiness <input type="checkbox"/> Blurred vision <input type="checkbox"/> Warm, dry, or flushed skin <input type="checkbox"/> Other _____	<p>Indicate treatment choices:</p> <input type="checkbox"/> Sugar-free fluids as tolerated _____ mg/dl <input type="checkbox"/> Check urine ketones if blood glucose over _____ <input type="checkbox"/> Notify parent if urine ketones positive. <input type="checkbox"/> May not need snack: call parent <input type="checkbox"/> See "Insulin Injections: Correction Dose of Insulin for High Blood Glucose" <input type="checkbox"/> Other _____
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MANAGEMENT OF VERY HIGH BLOOD GLUCOSE (over _____ mg/dl)

<p>Usual signs/symptoms for this student</p> <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Rapid, shallow breathing <input type="checkbox"/> Extreme thirst <input type="checkbox"/> Weakness/muscle aches <input type="checkbox"/> Fruity breath odor <input type="checkbox"/> Other _____	<p>Indicate treatment choices:</p> <input type="checkbox"/> Carbohydrate-free fluids if tolerated <input type="checkbox"/> Check urine for ketones <input type="checkbox"/> Notify parents per "Emergency Notification" section <input type="checkbox"/> If unable to reach parents, call diabetes care provider <input type="checkbox"/> Frequent bathroom privileges <input type="checkbox"/> Stay with student and document changes in status <input type="checkbox"/> Delay exercise. <input type="checkbox"/> Other _____
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MANAGEMENT OF LOW BLOOD GLUCOSE (below _____ mg/dl)

<p>Usual signs/symptoms for this child</p> <input type="checkbox"/> Hunger <input type="checkbox"/> Change in personality/behavior <input type="checkbox"/> Paleness <input type="checkbox"/> Weakness/shakiness <input type="checkbox"/> Tiredness/sleepiness <input type="checkbox"/> Dizziness/staggering <input type="checkbox"/> Headache <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Nausea/loss of appetite <input type="checkbox"/> Clamminess/sweating <input type="checkbox"/> Blurred vision <input type="checkbox"/> Inattention/confusion <input type="checkbox"/> Slurred speech <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Seizure <input type="checkbox"/> Other _____	<p>Indicate treatment choices:</p> <p><i>If student is awake and able to swallow,</i> <i>Give _____ grams fast-acting carbohydrate such as:</i></p> <input type="checkbox"/> 4oz. Fruit juice or non-diet soda or <input type="checkbox"/> 3-4 glucose tablets or <input type="checkbox"/> Concentrated gel or tube frosting or <input type="checkbox"/> 8 oz. Milk or <input type="checkbox"/> Other _____
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Retest BG 10-15 minutes 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 1/2 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