

LEON COUNTY SCHOOLS
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/Cell/Pager _____

MEAL PLAN TYPE: Carb insulin/Ratio Consistent Carbohydrate Other: _____
MEALS/SNACKS: Student can: Determine correct portions and number of carbohydrate serving Yes No
Calculate carbohydrate grams accurately Yes No

	Time/Location	Carb Content		Time/Location	Carb Content
<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	_____

Notify parent if outside food for party or food sampling provided to class. Yes No (Blood glucose correction will be done at next scheduled meal.)

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 (**Give snack if BG less than _____**)
 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 _____

INSULIN ADMINISTRATION DURING SCHOOL: Yes No School personnel not responsible for the administration of insulin
If yes, type of insulin: _____
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: Pen Pump (If pump worn, use "Supplemental Information Sheet for Student Wearing an Insulin Pump") Inhaled
Time to be given: Breakfast: (Before After); Lunch: (Before After); Other (Specify time; **not** "as needed"): _____
Insulin Dosing: Insulin correction formula Carbohydrate ratio Sliding scale Standard daily insulin

CORRECTION FACTOR: 1 unit of insulin for every _____ points that blood glucose is above or below target of _____
 Add carbohydrate dose to correction dose.
CARBOHYDRATE RATIO: 1 unit of insulin per _____ grams of carbohydrates consumed
Note: If pre-meal BG is less than target, the amount calculated for total insulin will be less than the amount calculated for food (carb) intake.

<p>SLIDING SCALE:</p> Blood sugar: _____ - _____ Insulin Dose: _____ Blood sugar: _____ - _____ Insulin Dose: _____	<p><input type="checkbox"/> STANDARD DAILY INSULIN DOSE at school (i.e. student is on predetermined number of units at prescribed time[s]):</p> Type of insulin: _____ Dose: _____ Time to be given: _____ _____ _____ _____ _____ _____ _____
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P.E., 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 all times.
Child should not exercise if blood glucose level is below _____ mg/dl **OR** if ketones are positive.

SUPPLIES TO BE FURNISHED/RESTOCKED BY PARENT/GUARDIAN: (Agreed-upon locations noted on emergency card/action plan)

- Blood glucose meter/strips/lancets/lancing device	- Other carbohydrate-containing snacks (crackers, candy)	<input type="checkbox"/> Insulin pen/pen needles/cartridges
- Fast-acting carbohydrates (juice, glucose tab, icing gel)	- Carbohydrate-free snack (e.g. cheese, beef jerky)	<input type="checkbox"/> Ketone testing strips
		<input type="checkbox"/> Glucagon Emergency Kit (if prescribed)

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
- Nausea; vomiting
- Abdominal pain
- Rapid, shallow breathing
- Fruity breath
- Other _____

Provide the following treatment:

- Sugar-free fluids as tolerated
- Check urine ketones if blood glucose over _____ mg/dl
- Notify parent if urine ketones positive.
- Frequent bathroom privileges

When more than trace ketones present:

- Stay with student and document changes in status.
- Call parent. If unable to reach parent, call diabetes care provider.
- **Delay exercise.**
- Student must be sent home.

Insulin administration for correction of high BG may be provided by trained school personnel via direct written/faxed order from diabetes care provider, or insulin may be administered by parent. Parent also may provide insulin instructions directly to students who are capable of self-injection or who can independently manage insulin pump.

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 _____

Provide the following treatment:

If student is awake and able to swallow, give 15 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 15 minutes after treatment

Repeat treatment until blood glucose over _____ mg/dl

Follow treatment with snack of _____

if more than 1 hour until next meal/snack or if going to activity

Other _____

IMPORTANT!!

Administer glucose gel if student is awake but has documented low blood glucose and is vomiting or unable to swallow. Notify parent. (If Glucagon is used, must call 911 – see below.)

If student is unconscious or having a seizure, presume the student has low blood glucose and:

Call 911 immediately. Notify parents after calling 911 and administering Glucagon or gel.

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

Student should be turned on his/her side and maintained in this “recovery” position until 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 (Required): _____

Date: _____

Physician's Signature (Required): _____

Date: _____

School Nurse's Signature: _____

Date: _____

This document follows the guiding principles outlined by the American Diabetes Association

Revised May 4, 2006

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: _____ Pump Insulin: Humalog Novolog Regular
 Insulin: Carbohydrate Ratios: 1 unit for every _____ grams of carbohydrates consumed Pre-programmed in pump: Yes No
 (Student to receive carbohydrate bolus after lunch)
 Insulin Correction Formula for Blood Glucose Over Target: 1 unit of insulin for every _____ points that blood glucose is above or below target of _____
 Pre-programmed in pump: Yes No

STUDENT PUMP SKILLS	ADDITIONAL COMMENTS:
1. Independently count carbohydrates. <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Calculate and administer carbohydrate bolus. <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Calculate and administer correction bolus. <input type="checkbox"/> Yes <input type="checkbox"/> No	

If pump alarms or insertion site becomes disconnected from the skin: **Notify parent.**

Student can:

- | | |
|--|--|
| 1. Disconnect pump if needed. <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 2. Change site. <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3. Give injection with pen, if needed and if pen available. <input type="checkbox"/> Yes <input type="checkbox"/> No | |

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

If blood glucose is tested _____ hour(s) after last bolus and it is above 300, follow these instructions:

- Check ketones.
- Call parent and inform them of blood sugar and ketone status. (Call even if ketones are negative.)
- Administer correction bolus, following Insulin Correction formula stated below:
 Blood glucose - _____ ÷ _____ = _____ units insulin
- Check blood sugar in 2 hours, if student is still in school at that time.
- If blood sugar is still above 300 after 2 hours, check ketones and 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 or disconnect 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
 - Detach set from skin
- Notify parent
- If pump was removed, send with EMS to hospital, or give to parent.

ADDITIONAL TIMES TO CONTACT PARENT:

- Soreness or redness at infusion site
- Leakage of insulin
- Other: _____

Effective Date(s) of Pump plan: _____

Parent's Signature (**Required**): _____ Date: _____

Diabetes Care Provider Signature (**Required**): _____ Date: _____

School Nurse's Signature: _____ Date: _____