

**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)

- |  |   |   |
|--|---|---|
| <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             |

**504 TESTING PERAMATERS:**

Blood Glucose should be between \_\_\_\_\_ and \_\_\_\_\_ for school tests.

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