

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)

- a. Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.
- b. Blood sugars in excess of _____ mg/dl
- c. Positive urine ketones.
- d. 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:
- | | |
|---|---|
| <input type="checkbox"/> Before breakfast | <input type="checkbox"/> Before PE/Activity Time |
| <input type="checkbox"/> Midmorning: before snack | <input type="checkbox"/> After PE/Activity Time |
| <input type="checkbox"/> Before breakfast | <input type="checkbox"/> Mid-afternoon |
| <input type="checkbox"/> Dismissal | <input type="checkbox"/> 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