

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 schoolIf yes, can student: Determine correct dose? ☐ Yes ☐ No Draw up correct dose? ☐ Yes ☐ NoGive 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 ☐ NoCorrection dose of insulin for high blood sugar: ☐ Yes ☐ NoIf yes, use: ☐ Regular ☐ Humalog ☐ NovologIf 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