

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: 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> <ul style="list-style-type: none"> <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> <ul style="list-style-type: none"> <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> <ul style="list-style-type: none"> <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> <ul style="list-style-type: none"> <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> <ul style="list-style-type: none"> <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> <ul style="list-style-type: none"> <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 _____ <p>Retest BG 10-15 minutes after treatment Repeat treatment until blood glucose over 80mg/dl Follow treatment with snack of _____</p> <p>if more than 1 hour till next meal/snack or if going to activity</p> <ul style="list-style-type: none"> <input type="checkbox"/> Other _____
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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