**School Year**       -       **Diabetes Medical Management Plan**--Effective date:

Parents: please complete this form to the best of your ability.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Student’s Name: | | | | | | | | | | | | DOB: | | | | | | | | | | Diabetes Type: | | | | | | | Date Diagnosed: | | | |
| School: | | | | | | | | | | | | | | | | | | | | | | Grade: | | | | | | | Home Room: | | | |
| Parent/Guardian #1: | | | | | | Home #: | | | | | | Cell #: | | | | | | | | | | | | | Work #: | | | | | | | |
| Parent/Guardian #2: | | | | | | Home #: | | | | | | Cell #: | | | | | | | | | | | | | Work #: | | | | | | | |
| Email: | | | | | | | | | | | Diabetes Healthcare Provider: | | | | | | | | | | | | Phone: | | | | | | | Fax: | | |
| ­**Student’s Self-Management Skills** | | | | | | | | | | | | | | | **NEEDS  Supervision/Assistance** | | | | | | | | | **DOES NOT NEED  Supervision/Assistance** | | | | | | | | |
| Performs and Interprets Blood Glucose Tests | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| Calculates Carbohydrate Grams | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| Determines Correction Dose of Insulin for High Blood Glucose | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| Determines Insulin Dose for Carbohydrate Intake | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| Administers Insulin by pump or injection | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| Troubleshoots alarms and malfunctions if using insulin pump | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| Disconnects/reconnects pump if needed | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| Calculates Dosages and administers insulin **without supervision**:  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Insulin Administration** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of Insulin at school | Regular | | | Humalog | | | | | | | Novolog | | Apidra | | | | | NPH | | | | | Lantus | | | Levemir | | | | | Other | |
| Insulin Delivery: | Syringe | | | Pen | | | | | | | Pump # of years on a pump:      . Child-Lock on? Yes  No | | | | | | | | | | | | | | | | | | | | | |
| **Are there other routine diabetes medications at school**? **If Yes, enter name of medication(s), dose, & time:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LOW Blood Sugar (HYPO-glycemia) – Test Blood Sugar to Confirm** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Student’s Usual Signs and Symptoms** (check all that apply)**:** Does the student recognize signs of **LOW** blood sugar?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Low Blood Sugar:** | | Hungry | | | | | | Weak/shaky/Pale | | | | | | | Headache | | | | | Dizziness | | | | | | | Inattention/confusion | | | | | |
| **Very Low**  **Blood Sugar:** | | Nausea or loss of appetite | | | | | | Slurred speech | | | | | | | Clamminess or sweating | | | | | Blurred  vision | | | | | | | Loss of consciousness | | | | | Other |
| **Management of Low Blood Glucose (below**       **mg/dl)**   1. If student is awake and able to swallow: give       grams fast-acting carbohydrates such as:  4 oz. fruit juice or non-diet soda or 3-4 glucose tablets or concentrated gel or tube frosting or 8 oz. milk or Other 2. Retest blood glucose 10-15 minutes after treatment. 3. Repeat the above treatment until blood glucose over       mg/dl. 4. Follow treatment with snack of       grams of carbohydrates if more than one hour until next meal/snack or if going to activity. 5. Notify Parent when blood glucose is below       mg/dl. 6. Delay exercise if blood glucose is below       mg/dl.   **If student is unconscious or having a seizure, call 911 immediately and notify parents. Position student on side if possible.**  **If wearing an insulin pump, place pump in suspend/stop mode or disconnect/cut tubing. If glucose gel available**:  **Glucose gel:**  One tube administered inside cheek and massage from outside while awaiting or during administration of Glucagon.  **Glucagon:**        mg administered by trained personnel**.** Glucagon is stored in       . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HIGH Blood Sugar (HYPER-glycemia)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Student’s Usual Signs and Symptoms** (check all that apply): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **High Blood Sugar:** | | Increased thirst and/or urination | | | | | | | Tired/drowsy | | | | | | | Blurred vision | | | | Warm, dry or flushed skin | | | | | | | | Weakness/muscle aches | | | | |
| **Very High**  **Blood Sugar:** | | Nausea/ vomiting | | | | | | | Abdominal pain | | | | | | | Extreme thirst | | | | Fruity breath odor | | | | | | | | Other | | | | |
| Does the student recognize signs of **HIGH** blood sugar **(HYPER-**glycemia)?  Yes  No  **Management of High Blood Glucose (over**       **mg/dl)**   1. Give water or other calorie-free liquids as tolerated and allow frequent bathroom privileges. 2. Check ketones if blood glucose over       mg/dl. 3. Notify parent if ketones positive and/or glucose over       mg/dl. 4. Refer to the Correction Dose section below | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Management of Very High Blood Glucose (over**       **mg/dl)**  **Treatment (In addition to treatment above):**   1. If unable to reach parents, call diabetes care provider. 2. Stay with student and document changes in status. 3. Delay exercise if blood glucose is above       mg/dl. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Retest blood glucose in       hours. | | | | | | | | | | Hold snack | | | | | | | | | Give snack | | | | | | | | | | | | | |
| **High Blood Sugar Correction Dose** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **The student’s target Blood Glucose range is**       to      . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Use Insulin Sliding Scale** | | | | | | | | | | | | | | **OR** | | | **Use Insulin Correction Dose Formula**  Determine insulin **correction dose** per c**orrection formula** below:  **Blood Glucose**       **(- minus)**  **Target Glucose**       **= Correction Amount**  **(÷ By) Correction Factor**       **=**  **Units of Insulin** | | | | | | | | | | | | | | | |
| Blood sugar       to | | | | | Insulin Dose =       units | | | | | | | | |
| Blood sugar       to | | | | | Insulin Dose =       units | | | | | | | | |
| Blood sugar       to | | | | | Insulin Dose =       units | | | | | | | | |
| Blood sugar       to | | | | | Insulin Dose =       units | | | | | | | | |
| Blood sugar       to | | | | | Insulin Dose =       units | | | | | | | | |
| Blood sugar       to | | | | | Insulin Dose =       units | | | | | | | | |
| **Blood Glucose Testing (Check what applies)** | | | | | | | | | | | | | | **Carbohydrate Intake and Insulin Dose** | | | | | | | | | | | | | | | | | | |
| **Test Blood** | | | **Time** | | | | **Give Correction?** | | | | | | | **# of Carb Grams** | | | | | | | **Insulin Dose or Carb Formula** | | | | | | | | | | | |
| Before Breakfast | | |  | | | | Y  N | | | | | | |  | | | | | | | One unit of insulin per       grams of carbs | | | | | | | | | | | |
| Before Morning Snack | | |  | | | | Y  N | | | | | | |  | | | | | | | One unit of insulin per       grams of carbs | | | | | | | | | | | |
| Before Lunch | | |  | | | | Y  N | | | | | | |  | | | | | | | One unit of insulin per       grams of carbs | | | | | | | | | | | |
| Before Afternoon Snack | | |  | | | | Y  N | | | | | | |  | | | | | | | One unit of insulin per       grams of carbs | | | | | | | | | | | |
| Before PE/Activity | | |  | | | | Y  N | | | | | | |  | | | | | | | One unit of insulin per       grams of carbs | | | | | | | | | | | |
| After PE/Activity | | |  | | | | Y  N | | | | | | |  | | | | | | | One unit of insulin per       grams of carbs | | | | | | | | | | | |
| Dismissal | | |  | | | | Y  N | | | | | | |  | | | | | | | One unit of insulin per       grams of carbs | | | | | | | | | | | |
| As needed for signs/symptoms.  Add carbohydrate dose to correction dose as indicated above?  Yes  No  **DO NOT give a correction dose if within**       **hours of the last bolus or injection.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

I understand that all treatments and procedures may be performed by the student and/or authorized trained school personnel. I also understand that the school is not responsible for damage/loss of equipment. **Snacks and supplies are to be furnished/restocked by parent.**

Parent’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_