DIABETES MEDICAL MANAGEMENT PLAN

School Year:

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Other emergency contact: _____ Phone #: _____ Relationship: _____

Insurance Carrier: _____ Preferred Hospital: _____

BLOOD GLUCOSE (BG) MONITORING: (Treat BG below _____mg/dl or above _____mg/dl as outlined below.)

☐ Before meals ☐ as needed for suspected low/high BG ☐ 2 hours after correction

☐ Midmorning ☐ Mid-afternoon ☐ Before dismissal

INSULIN ADMINISTRATION:

Insulin delivery system: ❑ Syringe or ❑ Pen or ❑ Pump **Insulin type:** ❑Humalog or ❑Novolog or ❑Apidra

MEAL INSULIN: (Best if given right **before eating**. For small children, can give within 15-30 minutes of the first bite of food-or right after meal)

☐ Insulin to Carbohydrate Ratio:
Breakfast: **1** unit per _____grams carbohydrate
Lunch: **1** unit per _____grams carbohydrate

☐ Fixed Dose per meal:
Breakfast: Give ____units/Eat _____grams of carbohydrate
Lunch: Give ____units/Eat _____grams of carbohydrate

CORRECTION INSULIN: (For high blood sugar. Add before *MEAL INSULIN to CORRECTION INSULIN* for *TOTAL INSULIN* dose.)

☐ Use the following correction formula
For pre-meal blood sugar over _____

(BG - ____) ÷ _____ = extra units insulin to provide

☐ Sliding Scale:
BG from _____to _____= _____units
BG from _____to _____= _____units
BG from _____to _____= _____units
BG from _____to _____= _____units
> _____= _____units

SNACK: ☐ A snack will be provided each day at: _____
Carbohydrate coverage only for snack (**No BG check required**):

☐ No coverage for snack
☐ **1** unit per _____grams of carb
☐ Fixed snack dose: Give ____units/Eat _____grams of carb

PARENTAL AUTHORIZATION to Adjust Insulin Dose:

☐ YES ☐ NO Parents/guardians are authorized to increase or decrease insulin-to-carb ratio within the following range:
1 unit per prescribed grams of carbohydrate, +/-_____grams of carbohydrate

☐ YES ☐ NO Parents/guardians are authorized to increase or decrease correction dose with the following range: +/-_____units of insulin

☐ YES ☐ NO Parents/guardians are authorized to increase or decrease fixed insulin dose with the following range: +/-_____units of insulin

MANAGEMENT OF LOW BLOOD GLUCOSE:

MILD low sugar: Alert and cooperative student (BG below _____)
- ☑ Never leave student alone
- ☑ Give 15 grams glucose; recheck in 15 minutes
- ☑ If BG remains below 70, retreat and recheck in 15 minutes
- ☑ Notify parent if not resolved
- ☐ If no meal is scheduled in the next hour, provide an additional snack with carbohydrate, fat, protein.

SEVERE low sugar: Loss of consciousness or seizure
- ☑ Call 911. Open airway. Turn to side.
- ☑ Glucagon injection IM/SubQ ❑ _____ ☑ 0.50mg
- ☑ Notify parent.
- ☑ For students using insulin pump, stop pump by placing in "suspend" or stop mode, disconnecting at pigtail or clip, and/or removing an attached pump. If pump was removed, send with EMS to hospital.

MANAGEMENT OF HIGH BLOOD GLUCOSE: (above _____mg/dl)
- ☐ Sugar-free fluids/frequent bathroom privileges.
- ☐ If BG is greater than 300 and it's been 2 hours since last dose, give ❑ **HALF** ❑ **FULL** correction formula noted above.
- ☐ If BG is greater than 300 and it's been 4 hours since last dose, give **FULL** correction formula noted above.
- ☐ If BG is greater than _____, check for ketones. Notify parent if ketones are present.
- ☐ Child should be allowed to stay in school unless vomiting with moderate or large ketones present.

MANAGEMENT DURING PHYSICAL ACTIVITY:

Student shall have easy access to fast-acting carbohydrates, snacks, and blood glucose monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below _____mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

- ☐ Check blood sugar right before physical education to determine need for additional snack.
- ☐ If BG is less than _____mg/dl, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.
- ☐ Student may disconnect insulin pump for 1 hour or decrease basal rate by _____.
- ☐ For new activities: Check blood sugar before and after exercise only until a pattern for management is established.
- ☐ A snack is required prior to participation in physical education.

SIGNATURE of AUTHORIZED PRESCRIBER (MD, NP, PA): _____ Date _____

Student's Name: _____ Date of Birth: _____

NOTIFY PARENT of the following conditions: (If unable to reach parent, call diabetes provider office.)

a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon.
b. Blood sugars in excess of 300 mg/dl, when ketones present.
c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

SPECIAL MANAGEMENT OF INSULIN PUMP:

☐ Contact Parent in event of: ▪ Pump alarms or malfunctions ▪ Detachment of dressing / infusion set out of place ▪ Leakage of insulin
▪ Student must give insulin injection ▪ Student has to change site ▪ Soreness or redness at site
▪ Corrective measures do not return blood glucose to target range within _____hrs.

☐ Parents will provide extra supplies including infusion sets, reservoirs, batteries, pump insulin, and syringes and ensure calibration of equipment.

This student requires assistance by the School Nurse or Trained Diabetes Personnel with the following aspects of diabetes management:

☐ Monitor and record blood glucose levels
☐ Respond to elevated or low blood glucose levels
☐ Administer glucagon when required
☐ Calculate and give insulin Injections
☐ Administer oral medication
☐ Monitor blood or urine ketones
☐ Follow instructions regarding meals and snacks
☐ Follow instructions as related to physical activity
☐ Respond to CGM alarms by checking blood glucose with glucose meter. Treat using Management plan on page 1.
☐ Insulin pump management: administer insulin, inspect infusion site, contact parent for problems
☐ Provide other specified assistance:
_____

This student may independently perform the following aspects of diabetes management:

Monitor blood glucose:
- ❑ in the classroom
- ❑ in the designated clinic office
- ❑ in any area of school and at any school related event

❑ Monitor urine or blood ketones
❑ Calculate and give own injections
❑ Calculate and give own injections with supervision
❑ Treat hypoglycemia (low blood sugar)
❑ Treat hyperglycemia (elevated blood sugar)
❑ Carry supplies for blood glucose monitoring
❑ Carry supplies for insulin administration
❑ Determine own snack/meal content
❑ Manage insulin pump
❑ Replace insulin pump infusion set
❑ Manage CGM

LOCATION OF SUPPLIES/EQUIPMENT: (Parent will provide and restock all supplies, snacks and low blood sugar treatment supplies.)
This section will be completed by school personnel and parent:

	Clinic room	With student		Clinic room	With student
Blood glucose equipment	❑	❑	Glucagon kit	❑	❑
Insulin administration supplies	❑	❑	Glucose gel	❑	❑
Ketone supplies	❑	❑	Juice /low blood glucose snacks	❑	❑

My signature provides authorization for the above Diabetes Mellitus Medical Management Plan.
I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

SIGNATURE of AUTHORIZED PRESCRIBER: _____ DATE: _____
Authorized Prescriber: MD, NP, PA

Name of Authorized Prescriber:

Address:

Phone:

SIGNATURES

I, (Parent/Guardian) _____ understand that all treatments and procedures may be performed by the student and/or Trained Diabetes 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 give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by Georgia state law.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____