

DIABETES MELLITUS MEDICAL MANAGEMENT PLAN
 School Year: 20__ to ____

Student's Name: _____ Date of Birth: _____

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

- Before meals
- 2 hours after correction
- as needed for suspected low/high BG
- Midmorning
- Mid-afternoon

INSULIN ADMINISTRATION: Dose determined by: Student Parent School nurse or Trained Diabetes Personnel

Insulin delivery system: Syringe Pen Pump

MEAL INSULIN: (It is 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 Type: Humalog Novolog Apidra

- Insulin to Carbohydrate Ratio: ____ unit per _____ grams carbohydrate
- Set Doses: Give ____ units (Eat _____ grams of carbohydrates)

CORRECTION INSULIN: (For high blood sugar. Add before meal insulin to correction/ sliding scale insulin for total meal time insulin dose.)

- Use the following correction formula (for pre lunch blood sugar over ____):
 $(BG - \underline{\quad}) \div \underline{\quad} = \text{extra units insulin to provide}$
- Sliding Scale:
 BG from _____ to _____ = _____ u
 BG from _____ to _____ = _____ u
 BG from _____ to _____ = _____ u
 BG from _____ to _____ = _____ u

MILD low sugar: Alert and cooperative student (BG below 70)

- 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 0.25 mg 0.50 mg 1.0 mg (M/SQ)
- 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 200 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 300 check for ketones. Notify parent if ketones are present.
- Note and document changes in status.
- Child should be allowed to stay in school unless vomiting and moderate or large ketones are 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 70 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 70 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 _____.
- At the beginning of a new activity 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.

MEAL PLAN:

- A snack will be provided each day at: _____
- If regularly scheduled meal plan is disrupted: call parent for care instructions

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.

DIABETES MELLITUS MEDICAL MANAGEMENT PLAN

School Year: 20 _____ to _____

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
- Administer insulin or oral medication
- Monitor blood or urine ketones
- Follow instructions regarding meals and snacks
- Follow instructions as related to physical activity
- 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 the school and at any school related activity
- Monitor urine or blood ketones
 - Administer insulin
 - 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

LOCATION OF SUPPLIES/EQUIPMENT: (To be completed by school personnel and parent. Parent to provide and restock snacks and low blood sugar supplies box.)

	Clinic room	With student		Clinic room	With student
Blood glucose equipment	<input type="checkbox"/>	<input type="checkbox"/>	Glucagon kit	<input type="checkbox"/>	<input type="checkbox"/>
Insulin administration supplies	<input type="checkbox"/>	<input type="checkbox"/>	Glucose gel	<input type="checkbox"/>	<input type="checkbox"/>
Ketone supplies	<input type="checkbox"/>	<input type="checkbox"/>	Juice / low blood glucose snacks	<input type="checkbox"/>	<input type="checkbox"/>

EMERGENCY NOTIFICATION: Notify parents of the following conditions:

- 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.
Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

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: _____

SIGNATURES: I 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 SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____

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.

- Dose/treatment changes may be relayed through parent.
- Student is due for medical appointment for review of diabetes management plan.

HEALTHCARE PROVIDER SIGNATURE: _____ Date: _____

Diabetes Care Provider: _____ Phone #: _____

Address: _____