Diabetes Medical Management Plan for School Year 20__-20__

Student: _____ DOB: _____

Child Care/School: _____ Teacher: _____ Classroom/Gr.: _____

1) Parent/Guardian: _____ Phone: (w) _____ (c) _____ (h) _____

2) Parent/Guardian: _____ Phone: (w) _____ (c) _____ (h) _____

3) Emergency contact: _____ Phone: (w) _____ (c) _____ (h) _____

Physician: _____ Phone: _____ Fax: _____

School Nurse: _____ Phone: _____ Fax: _____

Student's Self-Management Skills	Supervision Needed	No Supervision Needed
Performs and Interprets Blood Glucose Tests		
Calculates Carbohydrate Grams		
Determines Correction Dose for Carbohydrate Intake		
Determines Correction Dose for High Blood Glucose		
Student Self Administers Insulin Dose		

Medication at school

Insulin via: ☐Pump ☐ Syringe ☐ Pen ☐ none **Type of Insulin:**

Glucagon: ☐Yes ☐No Location in school: **Expiration:**

HEALTH CONCERN #1 **Low Blood Glucose (Hypoglycemia) < _____ mg/dl**

Student's usual signs and symptoms: Does student recognize signs and symptoms? Y or N						
LOW BLOOD SUGAR	☐Hungry	☐Weak/ Shaky	☐Headache	☐Dizziness	☐Inattention/ confusion	☐Other:_____
VERY LOW BLOOD SUGAR	☐Nausea/ No appetite	☐Slurred Speech	☐Clammy or sweating	☐Blurred Vision	☐Loss of Consciousness	☐Other:_____

Management of Low Blood Sugar (Below _____ mg/dl)

1. If Student is awake and able to swallow give 15 grams fast-acting carb. Such as: 4 oz. fruit juice or 3-4 glucose tablets or other:_____
2. Check blood sugar after 15 minutes.
3. Repeat the above treatment until blood glucose is 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 and School Nurse when blood glucose is below _____ mg/dl
6. Delay exercise if blood glucose is below _____ mg/dl

❖ Call 911 for the following:

1. Student is unable to eat or drink anything. Glucagon administered.
2. Decreasing alertness or consciousness.
3. Seizure

- **Glucose gel: One tube administered inside cheek and massaged from outside while waiting or during administration of Glucagon.**
- **Glucagon ____ mg injection administered by trained personnel. If child is unconscious, experiencing a seizure or unable to swallow. (Place student on side and CALL 911). Glucagon is stored in _____.**

Student Name:_____

HEALTH CONCERN #2 **High Blood Glucose (Hyperglycemia) >_____mg/dl**

Student's usual signs and symptoms:				**Does student recognize signs and symptoms? Y or N**		
HIGH BLOOD SUGAR	☐Increased thirst and/or urination	☐Tired/ drowsy	☐Blurred vision	☐Warm, dry or flushed skin	☐Weakness/ muscle aches	☐Other:_____
VERY HIGH BLOOD SUGAR	☐Nausea/ Vomiting	☐Abdominal Pain	☐Extreme Thirst	☐Fruity Breath Odor	☐High Ketones	☐Other:_____

Management of High Blood Sugar (Above _____ mg/dl)

1. Check Urine for Ketones if BS above _____
2. Monitor student.
3. Encourage water to drink, allow unlimited use of bathroom.
4. Notify parent and school nurse if:
   - blood sugar is above _____
   - ketones are moderate or high and or
   - experiencing nausea/vomiting
5. Recheck blood sugar in _____minutes and at _____intervals.
6. Delay exercise if ketones are moderate/high.

Management of VERY HIGH Blood Sugar (Over _____mg/dl)

In Addition to steps above:

If unable to reach parents stay with student and document physical changes in status and notify school nurse .

- ❖ Call 911 for the following: Labored breathing, Lethargic, Confused or Unconscious**.**

When hyperglycemia occurs other than at lunchtime:

- If it has been greater than 3 hours since the last dose of insulin, the student may be given insulin via injection using physician ordered sliding scale if approved by the school nurse and parent is notified**.**

Blood Glucose Testing	Insulin –Carb Ratio	Sliding Scale
☐Before Breakfast	____ unit: ___grams of carbs	Blood Sugar ____ to ___ Insulin Dose=_____units
☐Before Morning Snack		Blood Sugar ____ to ___ Insulin Dose=_____units
☐Before Lunch	____ unit: ___grams of carbs	Blood Sugar ____ to ___ Insulin Dose=_____units
☐Before Afternoon Snack		Blood Sugar ____ to ___ Insulin Dose=_____units
☐Before PE/Activity		Blood Sugar ____ to ___ Insulin Dose=_____units
☐After PE/Activity		Blood Sugar ____ to ___ Insulin Dose=_____units
☐Dismissal		Blood Sugar ____ to ___ Insulin Dose=_____units
☐ As needed for signs/symptoms		Blood Sugar ____ to ___ Insulin Dose=_____units
***** When symptomatic and no equipment available, treat for Hypoglycemia**		

Field Trips and Special Events:

Notify parents of all field trips/special events 2 weeks in advance. Trained/delegated staff should accompany student & provide necessary interventions for daily management and emergency care. All necessary supplies must accompany student throughout the trip.

Additional Information:

1. Student is allowed access to fast-acting glucose, to carry a water bottle and have unrestricted bathroom privileges.
2. Substitute teachers must be aware of the student's health situation and responsibilities.
3. *A student with diabetes is eligible for 504 accommodations.*
4. NOTE: Blood glucose levels can affect ability to concentrate and perform properly on tests. Prior to & during timed tests, standardized tests, etc. have student check their blood glucose. If blood glucose out of range, treat per care plan. Allow for student to continue taking test when student returns to normal range and asymptomatic.
5. Always have fast-acting sugar available in each classroom.

As parent/guardian of the above named student. I give my permission to the school nurse and other designated staff to perform and carry out the diabetes care as outlined in this Student Health Plan and for my child's health care provider to share information with the school nurse for the completion or alteration of this plan. I understand the information contained in this plan will be shared with school staff on a need to know basis.

Parent Signature		*Date:*
School Nurse Signature		*Date:*