

DIABETES MELLITUS MEDICAL MANAGEMENT PLAN

School Year: _____

Student's Name: _____ Date of Birth: _____

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

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:
 - Breakfast: 1 unit per _____ grams carbohydrate
 - Lunch: 1 unit per _____ grams carbohydrate
- Set Doses: Give _____ units
 - Eat _____ grams of carbohydrate

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** - _____) ÷ _____ = extra units insulin to provide
- Sliding Scale:
 - BG from _____ to _____ = _____ u
 - BG from _____ to _____ = _____ u
 - BG from _____ to _____ = _____ u
 - BG from _____ to _____ = _____ u
 - > _____ = _____ u

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 0.25 mg 0.50 mg 1.0 mg IM/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 _____ 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.
- 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.

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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.
- c. 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.

Student is due for medical appointment for review of diabetes management plan.

HEALTHCARE PROVIDER SIGNATURE: _____ Date: _____

Diabetes Care Provider: _____

Address: _____