Place student picture here

DIABETIC MEDICAL MANAGEMENT PLAN

General Information:

Student Name: _____ Grade/Teacher: _____

Emergency Contact: _____ Relation: _____

Contact Numbers: _____

Diagnosis: _____

BLOOD GLUCOSE CHECK and INSULIN THERAPY

Can child independently check own blood glucose? □Yes ☐With Supervision ☐No

Usual times of blood glucose checks:
☐Before Lunch ☐ _____hours after lunch
☐2 hours after correction dose ☐Mid-morning
☐Before PE ☐After PE
☐Before dismissal ☐As needed for signs/symptoms of low or high blood glucose ☐Before snack ☐As needed for signs/symptoms of illness
☐Before taking a test ☐Other: _____

Type of insulin: _____

Usual time of insulin injection: ☐Lunch ☐Snack ☐Correction Dose ☐Other: _____

Insulin delivery device: ☐Syringe ☐Insulin Pen ☐Insulin Pump

Can child give own insulin injection? ☐Yes ☐With Supervision ☐No

Insulin-to-Carbohydrate Ratio:

Lunch: ____ unit of insulin per _____ grams of carbohydrates (CHO).
Snack: ____ unit of insulin per _____ grams of carbohydrates (CHO).

Correction Dose:
Blood glucose correction factor/insulin sensitivity factor = _____.
Target Blood Glucose = _____mg/dL.

OTHER:

_____
_____
_____

HYPOGLYCEMIA

Usual symptoms when child presents with hypoglycemia (low blood glucose):

_____
_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose is less that _____mg/dL,

1. Give a quick-acting glucose product equal to 15 grams of carbohydrate.
2. Recheck blood glucose in 10-15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.
3. Additional Instructions:
   _____
   _____

If student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements) give:

1. **Glucagon:** ☐1mg ☐1/2 mg ☐_____ mg
2. **Route:** ☐SC ☐IM **Site:** _____
3. Call 911 and student's parents/guardian.

OTHER:

_____
_____
_____

HYPERGLYCEMIA

Student's usual symptoms of hyperglycemia (high blood glucose):

_____

_____

For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose:

1. Give correction dose of insulin.
2. Give extra water/non-sugar-containing drinks: _____ ounces per hour.
3. Check: ☐Urine ☐Blood for ketones every _____ hours when blood glucose levels are above _____ mg/dL.
4. Notify parents/guardians of onset of hyperglycemia.
5. Additional instructions:

   _____

   _____

If student has symptoms of hyperglycemia emergency such as dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness, depressed level of consciousness: Call 911 and student's parents/guardians.

OTHER:

_____

_____

_____

EXERCISE and ACADMEICS

Restrictions on activities, if any:

_____

_____

Child should NOT exercise if blood glucose is below _____mg/dL or above _____mg/dL.

Child should NOT participate in test taking if blood glucose is below _____mg/dL or above _____mg/dL.

Addition Instructions:

_____

_____

SUPPLIES/ SNACKS

Diabetic SUPPLIES will be kept: ☐With student ☐Front office/nurse office

Supply of SNACK FOODS will be kept: ☐With student ☐Front office/nurse office

Special event/party food permitted: ☐Parents/guardian discretion ☐Student discretion

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

_____

_____

OTHER:

_____

_____

_____

SIGNATURES

- I give permission to the school nurse or another qualified health care professional or trained diabetes personnel to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan.
- I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety.
- I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider if necessary.
- I will notify the school immediately if there is any change in the Diabetes Medical Management Plan.
- I will assume responsibility of safe delivery of diabetic medication and appropriates diabetic supplies to school.
- Our physician has reviewed this Diabetic Medical Management Plan and consents to the following plan.

Parent Signature: _____ Date: _____

Physician Signature: _____ Date: _____