

Diabetes Medical Management Plan

School District: _____ School: _____ School Year: _____ Grade: _____

Student Name: _____ DOB: _____

Provider Name: _____ Phone #: _____ Fax #: _____

Blood Glucose Monitoring at School

Blood Glucose Target Range: _____ - _____ mg/dl

Monitoring Schedule:

- Before breakfast
- Before lunch
- 10-20 min. before boarding bus
- Suspected hyper/hypoglycemia
- Is ill or requests testing
- Other: _____

Student Self Monitoring:

- Can test independently
- Needs supervision
- Needs assistance with testing and blood glucose management
- Other: _____

Diabetes Medication

Oral medications: Home: _____ School: _____

Insulin: (Opened insulin must be discarded after 28 days.)

- No insulin at School
- Insulin at Home: Humalog Novolog Lantus Other: _____
- Insulin at School: Humalog Novolog Lantus Other: _____

Insulin delivery device at school:

- Syringe & vial
- Insulin Pen
- Insulin Pump (See Pump Section.)

Insulin management at school:

- | | | | |
|---------------------|--|---|---|
| Student is able to: | Give own injections. | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> With supervision |
| | Draw up correct dose of insulin. | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> With supervision |
| | Determine correct amount of insulin. | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> With supervision |
| | Independently self manage pump or insulin injection. | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> With supervision |

Meals & Snacks at School

Independent in Carbohydrate calculations and management: Yes No Needs Supervision

Meal/Snack	Carbohydrate Count	Not on Fixed Carb Count	Meal/Snack	Carbohydrate Count	Not on Fixed Carb Count
Breakfast			Lunch		
Mid-morning Snack			Mid-morning Snack		

Snack before exercise: Yes No As Needed Snack after exercise: Yes No As Needed

Snack/content/amount at other times: As Needed OR _____

Food to avoid: Liquid sugars such as fruit juice, regular soda and Gatorade. Use only for low blood sugars.
Other: _____

Instructions when food provided in classroom (e.g. class party, food sampling): _____

Hypoglycemia (Low Blood Sugar) = _____ mg/dl and/or Physical Symptoms

Symptoms of Hypoglycemia:

Shaky Headache Confused Clumsy Sweaty Drowsy Hungry Pale
Uncooperative Irritable Weak Behavior Changes Other: _____

Precautions

Never leave this student unattended! If treatment is to be provided in the Health Office, a responsible adult needs to accompany the student to the Health Office.

Check blood sugar if student has not done so and is symptomatic.

Notify School Nurse and Parent when any of the following treatments are performed.

Low Blood Sugar Treatment:

- Give ½ cup (4 oz.) of juice or regular soda or 3-4 glucose tablets (or 15 grams of fast acting carbohydrate). Do not cover with insulin. The carbohydrate is given to treat the low blood sugar.
- Recheck blood glucose in 15 minutes. If blood sugar is still below _____ give another 15 grams of carbohydrate.
- If the student's blood sugar is above _____:
 - o Give breakfast/lunch and cover carbs with insulin per "carbohydrate counting and correction sheet"
 - OR
 - o If next meal is greater than _____ minutes away:
 - Give _____ gram snack, and DO NOT cover with insulin
 - Give protein snack with <_____ carbs, and DO NOT cover with insulin
- Make sure the student feels well before sending to lunch.
- Comments _____

Treatment if disoriented, combative, and incoherent but is conscious:

- Give ½ to 1 tube of glucose gel or cake decorating gel. Place gel between cheek and gum.
- Massage the outside of cheek to facilitate absorption through the membrane of the cheek.
- Encourage student to swallow.
- Recheck blood sugar in 10 minutes.
- If still below _____, repeat treatment as above.
- Give sugar containing liquid and snack when student is alert and able to swallow safely.
- Comments _____

Treatment for seizures, loss of consciousness, inability/unwillingness to take gel or juice:

- Stay with student
- Position student on side
- Give glucagon immediately by injection. Dose: 0.3cc 0.5cc 1.0cc
- Call 911
- Notify parents
- Comments _____

Hyperglycemia (High Blood Sugar) = _____ 250 or _____ 300 mg/dl

Symptoms of Hyperglycemia:

Extreme Thirst Frequent Urination Abdominal Pain Headache Nausea
Other: _____

Check Ketones:

- Urine should be checked for ketones when blood glucose levels are above 300 mg/dl.
- If urine ketones are moderate to large, CALL PARENT IMMEDIATELY!
- If student is on pump, and urine ketones are moderate to large OR blood ketones are 0.6mmol/l or more, call parents.

Treatment for ketones and/or high blood sugar:

- Increase sugar free liquid intake
- Allow student to use restroom as often as necessary
- Call parent immediately if student is vomiting

Treatment for high glucose with ketones, moderate, large or ≥ 0.6 or greater: (check all that apply)

- Call parent immediately for action plan
- Parent will determine the insulin coverage needed
- Follow blood sugar correction guidelines – see dosing sheet

Exercise and Sports

A fast-acting carbohydrate such as juice, regular soda, Gatorade, or glucose tablets need to always be available at the site of exercise or sports.

Individual Activity Restrictions for Student: Y N

If yes, list restrictions: _____

General Restrictions from Exercising:

If blood sugar is below **80 mg/dl**, treat for hypoglycemia with above fast acting carbohydrates.

Snack listed above should be given: Y N

If glucose is above **300 mg/dl** **OR** moderate to large urine ketones are present **OR** blood ketones are **≥ 0.6 mmol/L**, **Notify** physician or parent/guardian.

If student is symptomatic.

Supplies Kept at School

- | | | |
|--|--|--|
| <input type="checkbox"/> Blood glucose meter, test strips, meter batteries | <input type="checkbox"/> Glucagon Emergency Kit | <input type="checkbox"/> Fast-acting source of glucose |
| <input type="checkbox"/> Meter location: _____ | <input type="checkbox"/> Urine ketone strips | <input type="checkbox"/> Blood ketone meter and strips |
| <input type="checkbox"/> Insulin, pen, pen needles, insulin cartridges | <input type="checkbox"/> Insulin vials and syringes | <input type="checkbox"/> Insulin pump and supplies |
| <input type="checkbox"/> Lancet device, lancets, gloves, etc. | <input type="checkbox"/> Carbohydrate containing snack | |

Insulin Pump

Insulin Pump Care Information Attached

Student able to operate insulin pump: Y N With Supervision

Student can troubleshoot problems: Y N With Supervision
(e.g. Urine Ketones, pump malfunction)

Insulin Adjustments by Healthcare Provider or Parent (for use by School Nurse)

Date New Orders Obtained	Order * Note Change in Care Sheet	Nurse Signature
	<input type="checkbox"/> Verbal <input type="checkbox"/> Written	
	<input type="checkbox"/> Verbal <input type="checkbox"/> Written	
	<input type="checkbox"/> Verbal <input type="checkbox"/> Written	

SIGNATURES:

This Diabetes Medical Management Plan has been approved by:

Student Healthcare Provider Phone Date E-mail

Diabetes Educator Phone Date E-mail

I give my permission to the school, school nurse, licensed/unlicensed assistive personnel, and other designated staff member(s) to perform and carry out the diabetes care tasks as outlined by this Diabetes Medical Management Plan for my child, and I acknowledge that I have received a copy of the signed plan.

I also consent to the release of the information contained in this plan to all staff and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I will notify extra-curricular staff about health plan and care to be given during after school activities. I give my permission for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

Parent/Guardian Phone Date E-mail

Acknowledged and received by:

School Nurse Phone Date E-mail

Change in Care Management Plan

Student Name: _____ DOB: _____ New Order Date: _____

Carbohydrate Counting and Correction

Food: _____ units of Humalog/Novolog for every _____ grams of carbohydrate.

Blood Sugar: _____ units of Humalog/Novolog for every _____ mg/dl over _____ mg/dl.

Corrections for blood sugar can be made every 3 hours if needed.

Unless otherwise stated, cover all carbohydrates and snacks with insulin. Do not cover carbs used to treat low blood sugar.

PRE-MEAL Humalog/Novolog Doses

Blood Sugar Corrections

Food Carbohydrate

Under	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units

Not yet carb counting. Pre-meal novalog/humalog dose is _____ units before breakfast, _____ units before lunch, _____ units before dinner.

Lantus dose is: _____ AM _____ at bedtime.

Bed Time Corrections:

At bed time correct blood sugar level to _____

Bedtime & 3:00 AM Correction

Under	=	Units		to	=	Units
to	=	Units		to	=	Units
to	=	Units		to	=	Units
to	=	Units		to	=	Units

If blood sugar is less than _____ at bedtime, give _____ grams of carbohydrate + protein without Humalog/Novolog coverage for this snack.

- Change in Carb Counting and Blood Sugar correction per parent (if applicable).
- Change in Carb Counting and Blood Sugar correction per provider (if applicable).
- Additional changes to Initial Orders: _____

Signature _____

Printed Name _____

PREVENTING KETOACIDOSIS IN INSULIN PUMP USERS

Why are insulin pumpers at risk for ketoacidosis?

Pumpers have no long-acting insulin (Lantus or Levemir) in their bodies. If the flow of insulin from the pump stops, the body will make ketones very quickly.

What are the signs of high ketones?

- Nausea
- Stomach cramps
- Vomiting
- Trouble breathing

Usually blood sugar level is high when there is a high number of ketones, but ketoacidosis can occur if the blood sugar is under 200. A person may think he/she has the stomach flu when, in fact, he/she is becoming ill from high ketones. Symptoms are exactly the same. If insulin is not given immediately, ketoacidosis will result.

Test urine or blood for ketones if the following symptoms are present. (Check expiration date on strips; if blood ketone strips are past expiration date, the machine will not read them.)

- Feeling sick or nauseated
- Blood sugar over 300
- Blood sugar over 250 two times in a row

Follow directions below if ketones are present.

Less than 0.6 mmol/l Blood Ketones OR Trace/Small Urine Ketones

ADMINISTER correction bolus through insulin pump.

RECHECK blood sugar and ketones in 1 hour.

GIVE 4-8 oz. sugar free liquids by mouth every hour.

If blood sugar not improved in one hour, ADMINISTER insulin correction dose by syringe in amount equal to that recommended by the bolus wizard for the current blood sugar level.

REMOVE catheter and REPLACE insulin, cartridge, tubing and catheter.

RECHECK blood sugar in two hours.

ADMINISTER next bolus through pump with new set in place.

0.6 mmol/l to 3.0 mmol/l Blood Ketones OR Moderate to Large Urine Ketones

ADMINISTER correction dose of fresh insulin by syringe **immediately** in amount equal to that recommended by bolus wizard for the current blood sugar level.

GIVE 4-8 ounces sugar free liquids by mouth every hour.

REMOVE catheter and REPLACE insulin, cartridge, tubing and catheter.

RECHECK blood sugar and ketones every 2-3 hours.

ADMINISTER next bolus through pump with new set in place.

More than 3.0 mmol/l Blood Ketones

ADMINISTER **double** amount of correction insulin dose by syringe **immediately**.

REMOVE catheter and REPLACE insulin, cartridge, tubing and catheter.

CHECK blood sugar and ketones every 2-3 hours and set future correction doses using bolus wizard.

ADMINISTER 4-8 oz. of sugar free liquids every hour.

CALL the healthcare provider and parent/guardian.