Diabetes Medical Management Plan for School Year 2018-19

STUDENT NAME		*DOB*	
Emergency Contact #1	Parent's Name	Emergency Contact #2	Parent's Name
	Relationship		Relationship
	Home Phone		Home Phone
	Work Phone		Work Phone
	Cell Phone		Cell Phone
Health Care Provider: Dr. L. Rauch & Dr. A Meadows		Office Contact Person Tina/Cindy	
Office Phone 260-435-7427		Office FAX 260-435-6947	
Diagnosis: **DIABETES** ☐ Type 1 ☐ Type 2			

MONITORING (Physician Fill Out)

Target blood sugar range: 70 mg/dl – 120 mg/dl or 80 mg/dl – 150 mg/dl

BLOOD SUGAR MONITORING		
☐ YES ☐ NO	☐ Before meals	☐ Student requires assistance
	☐ For symptoms of hypo/hyperglycemia & anytime student does not feel well	☐ Student requires supervision
	☐ Before gym/activity	☐ Student is independent
	☐ After gym/activity	☐ Permission to self-carry
	☐ Before dismissal	**Where performed:** ☐ Clinic
	☐ Other______________________	☐ Classroom
		☐ Other____________________

Notify parent/guardian if blood sugar is ⬆ 300 mg/dl or ⬇ 50 mg/dl

KETONE TESTING: Check ketones if blood sugar is ⬆ 300 mg/dl. Also when student **is ill** or complains of nausea /vomiting/abdominal pain. See Page 3

*Notify parent/guardian if ketones are **moderate** or **large**. Notify physician if ketones are **moderate** or **large**.*

OUT-OF-RANGE BLOOD MANAGEMENT: *General guidelines for treating hyperglycemia and hypoglycemia will be followed according to the attached decision trees unless other instructions are specifically detailed by the health Care Provider.*

LOW BLOOD SUGAR (HYPOGLYCEMIA) **UNDER 70 mg/dl or 80 mg/dl**	HIGH BLOOD SUGAR (HYPERGLYCEMIA) **OVER 300 mg/dl**
✓ Check blood sugar ✓ Give 15 grams of fast-acting carbohydrate if blood sugar is ⬇ 70 mg/dl or ____ mg/dl and if the student is conscious and able to swallow. ✓ DOUBLE the amount of carbohydrates to 30 grams if blood sugar is ⬇ 50. ✓ Examples of 15 grams of fast-acting carb. * 4 oz. juice * 3-4 glucose tablets ✓ Retest blood sugar 15 minutes after treating	✓ Check blood sugar ✓ Check for keytons ✓ Have student drink 6-8 oz. of non-carb liquid every hour ✓ Notify parents and physician if ketones are *moderate* or *large*

✓ Repeat treatment if needed until blood sugar is ⬆ target blood sugar goal.	

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MEDICATION / INSULIN (Physician Fill Out)		
Insulin to be given during school hours: ☐ YES ☐ NO	☐ May calculate/give own injections with supervision ☐ Requires assistance to calculate injections ☐ Independently calculates own injections	
Insulin to be given by: ☐ Syringe and Vial ☐ Pen ☐ Pump (If by pump, see "Insulin Pumps Supplement")		
Injection sites to be used: ☐ Abdomen ☐ Legs ☐ Arms ☐ Hips (all does to be administered subcutaneously)		
Rapid-acting Insulin Type: ☐ Humalog ☐ Novolog ☐ Apidra ☐ Other _______________		
☐ INSULIN PER FIXED DOSE: Name of Insulin: Time: @ Mealtimes Dose:		
☐ INSULIN PER PUMP CALCULATIONS: see Pump Supplement		
☐ INSULIN USING CARBOHYDRATE COUNTING: **1 unit of _______ insulin per_______ grams of carbohydrate**	☐ With meals ☐ With snacks if over_______ grams of carbohydrate	
CORRECTION FOR HIGH BLOOD SUGARS ☐ at mealtimes unless otherwise notified by physician		
☐ Correction per ***"formula":*** Blood Sugar - _______ ÷ _______ = units of insulin needed	**OR**	☐ <u>Correction per ***"sliding scale":***</u> Blood sugar:__________ Units: __________ Blood sugar:__________ Units: __________ Blood sugar:__________ Units: __________ Blood sugar:__________ Units: __________ Blood sugar:__________ Units: __________ Blood sugar:__________ Units: __________ Blood sugar:__________ Units: __________ Blood sugar:__________ Units: __________

MEALS / SNACKS (Physician Fill Out) 1CARBOHYDRATE SERVING (1 CARB CHOICE) = 15 GRAMS CARBOHYDRATE (= 1 starch = 1 fruit = 1 milk)		
Can student calculate carbohydrate grams/choices accurately? ☐ YES ☐ NO		
Food	**Time**	**# CARB GRAMS /CHOICES**
Breakfast		
Morning Snack?		
Lunch		
Afternoon Snack?		
Before gym/activity?		
EXERCISE, SPORTS, TRANSPORTATION (Physician Fill Out)		

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GLUCAGON EMERGENCY INJECTION (Physician Fill Out)
If student is unconscious or having a seizure, assume it is a low blood sugar reaction. Call 911 immediately and notify parents. ☐ **Glucagon injection** (circle dose) **½ mg** or **1 mg** should be given SQ or IM by trained personnel. ☐ **Following injection, turn student on side until fully awake. When alert enough to swallow, give fast-acting carbohydrate as listed above.**

ITEMS TO BE FURNISHED BY PARENTS IMMEDIATELY UPON REQUEST	
☐ Blood glucose meter/strips/lancets/lancing device ☐ Insulin vials, syringes, pens, needles, cartridges, etc. ☐ Ketone testing strips ☐ Fast-acting carbohydrate foods for lows ☐ Oral medication for diabetes if ordered	☐ Carbohydrate free beverages/water bottles for highs ☐ Glucagon Emergency Kit ☐ Routine daily snacks if ordered ☐ Glucose tablets ☐ Diabetes paperwork and updated orders

STATEMENT OF RESPONSIBILITY (Parent Read)

Parents/Guardians are responsible to:

- Notify school personnel of all changes in their child's medical management plan.
- Give permission for the school nurse to consult with student's Health Care Provider when necessary.
- Provide an adequate amount of all necessary diabetes supplies for student at all times.
- Provide current information on how to be contacted if necessary due to student's medical needs.
- Designate a knowledgeable person who will be available to be contacted, and who will be responsible for the student if the school is unable to contact parents/guardians.
- Make sure that the medical management plan is updated at least yearly and that the school has a copy.

School Personnel are responsible to:

- Follow medical management plan as outlined above while student is at school.
- Notify parents/guardians of any required treatment for low and/or high blood sugars.
- Provide copies of blood sugar logs and care given to parents and Health Care Providers upon request.
- Notify parents/guardians when supplies need replenished.

If a Diabetes Medical Management Plan for the current school year is not provided to the school, the most recent plan available will be followed until the school receives an updated one.

Signatures: *The following have read and agree to adhere to the above plan (and pump supplement if using pump.) Parents agree to give permission to the school nurse, trained diabetes personnel, and other designated school staff members to perform and carry out the diabetes care tasks as outlined by the student's Diabetes Medical Management Plan. Parents also consent to the release of the information contained in this Diabetes Medical Management Plan, including child's photo to all staff members and other adults who have custodial care of the child and who may need to know this information to maintain the child's health and safety.*

Health Care Provider:	Date
Parent/Guardian:	Date
Student:	Date
School Nurse:	Date