**Polk County School Board Health Services** for School Year       -       **Diabetes Medical Management Plan**--Effective date:

Parents: please complete this form to the best of your ability.

|  |  |  |  |
| --- | --- | --- | --- |
| Student’s Name:       | DOB:       | Diabetes Type:       | Date Diagnosed:       |
| School:       | Grade:       | Home Room:       |
| Parent/Guardian #1:       |  Home #:        | Cell #:       | Work #:       |
| Parent/Guardian #2:       | Home #:        | Cell #:       | Work #:       |
| Email:       | Diabetes Healthcare Provider:        | Phone:       | Fax:       |
| ­**Student’s Self-Management Skills** | **NEEDS Supervision/Assistance** | **DOES NOT NEED Supervision/Assistance** |
| Performs and Interprets Blood Glucose Tests | [ ]  | [ ]  |
| Calculates Carbohydrate Grams | [ ]  | [ ]  |
| Determines Correction Dose of Insulin for High Blood Glucose | [ ]  | [ ]  |
| Determines Insulin Dose for Carbohydrate Intake | [ ]  | [ ]  |
| Administers Insulin by pump or injection  | [ ]  | [ ]  |
| Troubleshoots alarms and malfunctions if using insulin pump | [ ]  | [ ]  |
| Disconnects/reconnects pump if needed | [ ]  | [ ]  |
| Calculates Dosages and administers insulin **without supervision**: [ ]  Yes [ ]  No |
| **Insulin Administration** |
| Type of Insulin at school  | [ ]  Regular | [ ]  Humalog | [ ]  Novolog | [ ]  Apidra | [ ] NPH | [ ]  Lantus | [ ] Levemir | [ ]  Other      |
| Insulin Delivery: | [ ]  Syringe | [ ]  Pen | [ ]  Pump # of years on a pump:      . Child-Lock on? [ ] Yes [ ]  No |
| **Are there other routine diabetes medications at school**? **If Yes, enter name of medication(s), dose, & time:** |
| **LOW Blood Sugar (HYPO-glycemia) – Test Blood Sugar to Confirm** |
| **Student’s Usual Signs and Symptoms** (check all that apply)**:**Does the student recognize signs of **LOW** blood sugar? [ ]  Yes [ ]  No |
| **Low Blood Sugar:** | [ ]  Hungry | [ ]  Weak/shaky/Pale | [ ]  Headache | [ ]  Dizziness  | [ ]  Inattention/confusion |
| **Very Low****Blood Sugar:** | [ ]  Nausea or loss of appetite | [ ]  Slurred speech | [ ]  Clamminess or sweating | [ ]  Blurred vision | [ ]  Loss of consciousness | [ ]  Other       |
| **Management of Low Blood Glucose (below**       **mg/dl)**1. If student is awake and able to swallow: give       grams fast-acting carbohydrates such as: 4 oz. fruit juice or non-diet soda or 3-4 glucose tablets or concentrated gel or tube frosting or 8 oz. milk or Other
2. Retest blood glucose 10-15 minutes after treatment.
3. Repeat the above treatment until blood glucose 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 when blood glucose is below       mg/dl.
6. Delay exercise if blood glucose is below       mg/dl.

**If student is unconscious or having a seizure, call 911 immediately and notify parents. Position student on side if possible.**  **If wearing an insulin pump, place pump in suspend/stop mode or disconnect/cut tubing. If glucose gel available**: [ ]  **Glucose gel:**  One tube administered inside cheek and massage from outside while awaiting or during administration of Glucagon.[ ]  **Glucagon:**        mg administered by trained personnel**.** Glucagon is stored in       . |
| **HIGH Blood Sugar (HYPER-glycemia)** |
| **Student’s Usual Signs and Symptoms** (check all that apply): |
| **High Blood Sugar:** | [ ]  Increased thirst and/or urination | [ ]  Tired/drowsy | [ ]  Blurred vision | [ ]  Warm, dry or flushed skin | [ ]  Weakness/muscle aches |
| **Very High** **Blood Sugar:** | [ ]  Nausea/vomiting | [ ]  Abdominal pain | [ ]  Extreme thirst | [ ]  Fruity breath odor | [ ]  Other       |
| Does the student recognize signs of **HIGH** blood sugar **(HYPER-**glycemia)? [ ]  Yes [ ]  No**Management of High Blood Glucose (over**       **mg/dl)** 1. Give water or other calorie-free liquids as tolerated and allow frequent bathroom privileges.
2. Check ketones if blood glucose over       mg/dl.
3. Notify parent if ketones positive and/or glucose over       mg/dl.
4. Refer to the Correction Dose section below
 |
| **Management of Very High Blood Glucose (over**       **mg/dl)** **Treatment (In addition to treatment above):** 1. If unable to reach parents, call diabetes care provider.
2. Stay with student and document changes in status.
3. Delay exercise if blood glucose is above       mg/dl.
 |
| Retest blood glucose in       hours. | [ ]  Hold snack | [ ]  Give snack |
| **High Blood Sugar Correction Dose** |
| **The student’s target Blood Glucose range is**       to      . |
| [ ]  **Use Insulin Sliding Scale** | **OR** | [ ]  **Use Insulin Correction Dose Formula**Determine insulin **correction dose** per c**orrection formula** below:**Blood Glucose**       **(- minus)** **Target Glucose**       **= Correction Amount**      **(÷ By) Correction Factor**       **=**  **Units of Insulin** |
| Blood sugar       to       | Insulin Dose =       units |
| Blood sugar       to       | Insulin Dose =       units |
| Blood sugar       to       | Insulin Dose =       units |
| Blood sugar       to       | Insulin Dose =       units |
| Blood sugar       to       | Insulin Dose =       units |
| Blood sugar       to       | Insulin Dose =       units |
| **Blood Glucose Testing (Check what applies)** | **Carbohydrate Intake and Insulin Dose** |
| **Test Blood** | **Time** | **Give Correction?** | **# of Carb Grams** | **Insulin Dose or Carb Formula** |
| [ ]  Before Breakfast |       | [ ]  Y [ ]  N |       | One unit of insulin per       grams of carbs |
| [ ]  Before Morning Snack |       | [ ]  Y [ ]  N |       | One unit of insulin per       grams of carbs |
| [ ]  Before Lunch |       | [ ]  Y [ ]  N |       | One unit of insulin per       grams of carbs |
| [ ]  Before Afternoon Snack |       | [ ]  Y [ ]  N |       | One unit of insulin per       grams of carbs |
| [ ]  Before PE/Activity |       | [ ]  Y [ ]  N |       | One unit of insulin per       grams of carbs |
| [ ]  After PE/Activity |       | [ ]  Y [ ]  N |       | One unit of insulin per       grams of carbs |
| [ ]  Dismissal |       | [ ]  Y [ ]  N |       | One unit of insulin per       grams of carbs |
| [ ]  As needed for signs/symptoms.Add carbohydrate dose to correction dose as indicated above? [ ]  Yes [ ]  No**DO NOT give a correction dose if within**       **hours of the last bolus or injection.**  |

I understand that all treatments and procedures may be performed by the student and/or authorized trained school personnel. I also understand that the school is not responsible for damage/loss of equipment. **Snacks and supplies are to be furnished/restocked by parent.**

Parent’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_