DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL

Effective Date: ____________________

Student: ____________________ **DOB:** ____________________

Student ID#: ____________________ **School:** ____________________

Type of Diabetes: ☐ **Type 1** ☐ **Type 2** **Date of Diagnosis:** ____________

☐ Other: ____________________

Blood glucose Monitoring

☐ Meter Type: ____________ ☐ **Blood glucose target range:** _____-_____ **mg/dl**

☐ Blood glucose monitoring times: ____________________

☐ For suspected hypoglycemia ☐ At student's discretion excluding suspected hypoglycemia

☐ No blood glucose monitoring at school ☐ Supervision of monitoring and results

☐ Permission to monitor independently

☐ Assistance with monitoring and results.

☐ Check blood glucose 10 to 20 minutes before boarding bus.

Diabetes Medication

☐ No insulin at school: Current insulin at home: ____________________

☐ Oral diabetes medication at school: ____________________

☐ Insulin at school: ☐ Humalog ☐ Novolog ☐ Apidra ☐ Other: ____________

Insulin delivery device: ☐ Syringe and vial ☐ Insulin pen ☐ Insulin pump

Insulin dose for school: ____________________

Standard lunchtime dose: ____________________

☐ Meal bolus: _______ units of insulin per ________ grams of carbohydrate.

☐ Correction for blood glucose: _______ units of insulin for every ______ md/dl above _________ mg/dl.

(Correction bolus can be given with meals or every 3 hours if blood glucose levels are high)

Correction Scale

Blood Glucose Value (mg/dl)	Units of Insulin
Less than 100	
100-150	
151-200	
201-250	
251-300	
301-350	
352-400	
More than 400	

Note: Insulin dose is a total of meal bolus and correction bolus.

☐ Parent/Guardian may adjust insulin doses within the following range: ____________________

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HELPING ADMINISTER TO THE NEEDS OF THE STUDENT WITH DIABETES IN SCHOOL

DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL

Meal Plan

1 carbohydrate choice = ____________ Grams of carbohydrate

☐ Meal plan prescribed (see below) ☐ Meal plan variable

Breakfast Time: ________________ # of carb choices = ______________________

Morning Snack Time: ____________ # of carb choices = ______________________

Lunch Time: ___________________ # of carb choices = ______________________

Afternoon Snack Time: ___________ # of carb choices = ______________________

☐ Plan for pre-activity: ____

☐ Plan for after school activities: ____________________________________

☐ Plan for class parties: ____

☐ Extra food allowed: ☐ Parent/guardian's discretion ☐ Student's discretion

Hypoglycemia

Blood Glucose < _____ mg/dl

☐ Self treatment of mild lows ☐ Assistance for all lows

☐ Immediately treat with 15 gm of fast-acting carbohydrate (e.g.; 4 oz juice, 3-4 glucose tabs, 6oz regular soda, 3 tsp glucose gel)

☐ Recheck blood glucose in 15 minutes and repeat 15 gm of carbohydrate if blood glucose remains low.

☐ If more than 1 hour until next meal or snack student should have another 15 gm of carbohydrate.

☐ If child will be participating in additional exercise or activity before the next meal, provide an additional carbohydrate choice.

☐ If student is using an insulin pump, suspend pump until blood glucose is back in goal range.

Severe Hypoglycemia

If the child is unconscious or having seizures due to low blood glucose immediately administer injection of: **Glucagon _________ mg (glucagon emergency kit)**

- Immediately after administering the Glucagon, turn the student onto their side. Vomiting is a common side effect of Glucagon.
- Notify parent/guardian and EMS per protocol

Hyperglycemia

Blood Glucose > _____ mg/dl

☐ Check ketones when blood glucose > ______ mg/dl or student is sick.

☐ Use Correction Scale insulin orders when blood glucose is _________ mg/dl.

☐ Unlimited bathroom pass.

☐ Notify parent immediately of blood glucose > _______ mg/dl or if student is vomiting.

☐ If student is using an insulin pump, follow DKA prevention protocol

Special Occasions

☐ Arrange for appropriate monitoring and access to supplies on all field trips.

____
Signature of Physician/Licensed Prescriber   Date

____
Print name of Physician/Licensed Prescriber

______________________________ ____________________ ____________________
Clinic Address   Phone   Fax

Returned to: ______________________________ ____________________ ____________________
RN, School Nurse   Phone   Fax

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Student: ______________________
DOB: ______________________
Student ID #: ______________________

DIABETES QUESTIONNAIRE

Please complete and return to the School Nurse.
The following information is helpful in determining any special needs. School year: ____________

Person to contact:	Relationship:	Work Phone:	Home Phone:
1. ____________	____________	____________	____________
2. ____________	____________	____________	____________

Preferred Communication method: ☐ Phone ☐ Written ☐ In Person ☐ Email: ____________

Health Care Provider	Clinic:	Phone:
Hospital:	Phone:	

Child's age at diagnosis of diabetes: ____________

Does your child wear a medical alert bracelet/necklace? ☐ Yes ☐ No

Will your child need routine snacks at school? ☐ A.M. ☐ P.M. ☐ as needed
(Snacks will need to be provided by the family)
What would you like done about birthday treats and/or party snacks? ____________

What time should your child's blood sugar be monitored? ☐ A.M. ☐ P.M. ☐ as needed ☐ not needed
(Authorization by a health care provider is required.)

Does your child know how to check his/her own blood sugar? ☐ Yes ☐ No

Will your child need to test his/her urine for ketones at school? ☐ Yes ☐ No

Will your child need to test his/her blood for ketones at school? ☐ Yes ☐ No

What blood sugar level is considered low for your child? below ____________

How often does your child typically experience low blood sugar? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ____________

When does he/she typically experiences low blood sugar:
☐ mid A.M. ☐ before lunch ☐ afternoon ☐ after exercise ☐ other ____________

Please check your child's usual signs/symptoms of low blood sugar.

- ☐ hunger or "butterfly feeling"
- ☐ shaky/trembling
- ☐ dizzy
- ☐ sweaty
- ☐ rapid heartbeat
- ☐ pale
- ☐ irritable
- ☐ weak/drowsy
- ☐ inappropriate crying or laughing
- ☐ severe headache
- ☐ impaired vision
- ☐ anxious
- ☐ difficulty with speech
- ☐ difficulty with coordination
- ☐ confused/disoriented
- ☐ loss of consciousness
- ☐ seizure activity
- ☐ other

Does he/she recognize these signs/symptoms? ☐ Yes ☐ No

In the past year, how often has your child been treated for severe low blood sugar? ____________

In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital ☐

In the past year, how often has your child been treated for severe high blood sugar or diabetic ketoacidosis? ____________

In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital ☐

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DIABETES QUESTIONNAIRE

What do you usually do to treat low blood sugar at home? Please be specific and state exact amount of food, beverage, glucagon, etc. (All supplies must be provided by the family if needed at school.) ______________________
Please indicate your child's skill level for the following:

Skill	Does alone	Does with help	Done by adult	Comments
Obtain glucose sample				
Reads meter and records				
Counts carbs for meals/snack				
Interprets sliding scale				
Selects insulin injection site				
Measures insulin				
Administers insulin				
Measures ketones				
Pump skills				

Insulin taken on a regular basis:

Name	Type	Units	Time of day	Delivery Method (Pen, syringe, pump)

Does your child use an insulin to carbohydrate ratio? Yes ☐ No ☐ Ratio: __________

Does your child adjust the insulin dose for high or low blood sugar? Yes ☐ No ☐ Correction factor (insulin sensitivity): __________

Other medication taken on regular basis:

Name	By (mouth, injection, etc)	Dose	Time of Day

As needed medication:

Name	By (mouth, injection, etc)	Dose	Time of Day

Please list any known medication side effects that may affect your child's learning and/or behavior:

____

____

If a medication is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of medication if the student is deemed capable. The medication must be in the original labeled container. When you get the prescription filled, please ask the pharmacist to put it into two containers so the student will have one for school and one for home use.

What action do you want school personnel to take if your child's does not respond to treatment/medication?

____

____

In an acute emergency, the student will be transported by paramedics to the hospital. Transportation in a non-acute situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

Has your child received diabetes education? ☐ by health care provider ☐ at support group ☐ at camp ☐ other

Please add anything else that you would like school personnel to know about your child's diabetes (or related health conditions).

____

____

Information was provided by ______________________ ______________________ ______________
Name | Relationship to Student | Date

I authorize reciprocal release of information related to diabetes mellitus between the school nurse and the health care provider.

______________________________________ ______________________
Parent/Guardian | Date

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Student: ______________________ Grade/Age: ______________ Date: ______________

DIABETES CARE TASKS CHECKLIST

Determining Student Independence in Diabetes Management at School

NURSING ASSESSMENT

This checklist is part of the nursing assessment completed by the school nurse within the school setting. The student's age, developmental level and factors inherent to the school environment will influence the degree of competency. Determining whether or not a student is competent at school with the following tasks will provide direction for the degree of independence expected from the student with diabetes. It is recommended that findings obtained from this nursing assessment done at school be reviewed with the parent/guardian and/or health care provider. The school nurse then uses this data to develop the student's Individual Health Care Plan.

INSTRUCTIONS: Check off those tasks the student is able to competently perform in the school setting, providing an indication of the student's level of independence with managing their diabetes at school.

BLOOD GLUCOSE MONITORING

- ☐ Verifies code of meter matches test strips
- ☐ Inserts test strip
- ☐ Operates lancing device
- ☐ Pierces skin appropriately
- ☐ Places drop of blood on test strip
- ☐ Disposes of materials appropriately
- ☐ Records results
- ☐ Informs appropriate school health care team member of results
- ☐ Takes correct action based on the result
- ☐ Properly stores equipment

KETONE TESTING

- ☐ Collects specimen appropriately (urine or blood)
- ☐ URINE – Uses correct test strip
- ☐ Dips test strip into urine
- ☐ BLOOD – Verifies code of meter matches test strips
- ☐ Inserts test strip and applies blood
- ☐ Disposes of materials appropriately
- ☐ Records results
- ☐ Informs appropriate school health care team of results
- ☐ Takes correct action based on the result
- ☐ Properly stores equipment

INSULIN ADMINISTRATION - INJECTION

- ☐ Selects appropriate injection site
- ☐ Able to calculate insulin dose based on blood glucose level
- ☐ SYRINGE – Draws up correct dose in syringe
- ☐ PEN – Dials correct dose
- ☐ Expels air
- ☐ Pinches up skin for injection
- ☐ Injects insulin
- ☐ Records administration – dose, time, date, site
- ☐ Properly stores equipment

INSULIN ADMINISTRATION PUMP

Refer to Insulin Pump Therapy – Student Performance Assessment

NUTRITION

- ☐ Identifies key components of prescribed meal plan
- ☐ Identifies correct portion sizes for meal plan
- ☐ Able to correctly identify carbohydrate content in foods (if appropriate)
- ☐ Able to calculate insulin to food intake, per IHP

ACTIVITY

- ☐ Verbalizes role of exercise in calculating insulin needs
- ☐ Carries correct supplies when engaged in physical activity
- ☐ Correctly adjusts carbohydrate intake with activity (per IHP)
- ☐ Informs coaches and/or PE teachers about diabetes health needs

RECOGNIZING IMPENDING HYPOGLYCEMIA

- ☐ Verbalizes own signs and symptoms of hypoglycemia
- ☐ Recognizes signs and symptoms of hypoglycemia
- ☐ Takes correct actions (per IHP) when signs & symptoms of hypoglycemia re recognized
- ☐ Informs appropriate school personnel about diabetes health needs

______________________ ______________________
School Nurse (Signature Date

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