

DIABETES MEDICAL MANAGEMENT PLAN

Student's Name: _____

Date of Birth: _____ Medical Record #: _____

BLOOD GLUCOSE MONITORING

Student routinely checks blood glucose prior to insulin administration at meal time. Student may check blood glucose as needed throughout the school day.

INSULIN DOSING

Type of insulin: Novolog or Humalog or Apidra

INSULIN PUMP: FOLLOW INSULIN DOSE PER PUMP DIRECTIONS

Meal time insulin dose to be given pre-meal unless alternative checked: post-meal either pre- or post-meal

Insulin dosing not to be used for snacks unless this box checked .

<i>Before school meal</i>	<i>Lunch</i>	<i>After school meal</i>
Insulin dose = _____ units Insulin dose = _____ units/_____ grams of carbohydrates	Insulin dose = _____ units Insulin dose = _____ units/_____ grams of carbohydrates	Insulin dose = _____ units Insulin dose = _____ units/_____ grams of carbohydrates
Sliding Scale: (DO NOT USE IF WITHIN 3 HOURS OF PREVIOUS INSULIN DOSE).		
_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl	_____ units if blood glucose is _____ to _____ mg/dl
<i>Sliding scale is based on correction factor of _____ units/_____ mg/dl blood sugar.</i>	<i>Sliding scale is based on correction factor of _____ units/_____ mg/dl blood sugar.</i>	<i>Sliding scale is based on correction factor of _____ units/_____ mg/dl blood sugar.</i>

School Nurse (licensed RN) may decrease total insulin dosage.

Student's Level of Independence:

- | | | | | | | |
|--|--------------------------|----|--------------------------|------------------|--------------------------|-----|
| Student can perform own blood glucose checks? | <input type="checkbox"/> | No | <input type="checkbox"/> | With Supervision | <input type="checkbox"/> | Yes |
| Student can calculate carbohydrates independently? | <input type="checkbox"/> | No | <input type="checkbox"/> | With Supervision | <input type="checkbox"/> | Yes |
| Student can determine correct amount of insulin? | <input type="checkbox"/> | No | <input type="checkbox"/> | With Supervision | <input type="checkbox"/> | Yes |
| Student can draw correct dose of insulin? | <input type="checkbox"/> | No | <input type="checkbox"/> | With Supervision | <input type="checkbox"/> | Yes |
| Student can give own injections? | <input type="checkbox"/> | No | <input type="checkbox"/> | With Supervision | <input type="checkbox"/> | Yes |
| Student may carry own diabetic supplies (ie pen/glucometer)? | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes | | |
| Student can bolus correctly (for carbohydrates or for correction of hyperglycemia) | <input type="checkbox"/> | No | <input type="checkbox"/> | With Supervision | <input type="checkbox"/> | Yes |
| Student can troubleshoot alarms and malfunctions? | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes | | |

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HYPOGLYCEMIA (Low Blood Sugar)

If conscious and able to swallow:

If blood glucose is < 80 mg/dl, give 15 grams of carbohydrates and recheck blood glucose in 15 minutes.
Repeat until blood glucose is > 80mg/dl.

If unconscious or having seizure, give Glucagon injection IM:

0.5 mg

1.0 mg

If Glucagon is indicated, administer it simultaneously while calling 911 and the parents/guardians.

HYPERGLYCEMIA (High Blood Sugar)

Check urine ketones if blood glucose > 350 mg/dl.

Give insulin per sliding scale orders (DO NOT USE WITHIN 3 HOURS OF PREVIOUS INSULIN DOSE).

❖ *IF KETONES are MODERATE or LARGE and student has symptoms, student will be sent home.*

PHYSICIAN'S AUTHORIZATION & PARENT CONSENT

FOR DIABETES MEDICAL MANAGEMENT PLAN

My signature below provides authorization for this Diabetes Medical Management Plan. I understand that in some school districts specialized health care services may be observed by unlicensed designated school personnel under the training provided by a school nurse or RN. **This authorization is for the current school year. If changes are indicated, I will provide new written authorization.**

Physician's Name (Print): _____

Physician's Signature: _____ Date: _____

Kaiser (Roseville) Sutter UC Davis Other: _____

Physician's Telephone: () _____ - _____ Physician's Fax: () _____ - _____

My signature below provides consent for designated school personnel to assist my child with the above medication.

Parent's Name (Print): _____ Telephone: () _____ - _____

Parent/Guardian Signature: _____ Date: _____

This form was created in collaboration with Sutter Center of Excellence in Diabetes and Endocrinology, UC Davis Children's Hospital, Kaiser Pediatric Endocrinology, San Juan USD, Natomas USD, Sac City USD, Twin Rivers USD, Elk Grove USD, Rocklin USD, Vallejo USD, Vacaville USD, Folsom Cordova USD, Sacramento County Office of Education, Placer County Office of Education, California School Nurses Organization, Sac State Division of Nursing.