Student Name: School Year:

WAYNE RESA Leading... Learning for All | SERVICE LEADERSHIP COLLABORATION EXCELLENCE

School-based Medical Management Plan for the Student with Diabetes Mellitus

To be completed by Parent/Guardian

Name: _____ Birthdate: _____ Grade: _____

Address: _____

Mother/Guardian: _____ Phone: (home) _____ (cell) _____

Father/Guardian: _____ Phone: (home) _____ (cell) _____

Other Emergency Contact: _____ Phone: _____ Relationship: _____

Symptoms: (check student's usual symptoms)

Hypoglycemia (low blood sugar)	Hyperglycemia (high blood sugar)
☐ Shaky ☐ Weak ☐ Sweaty ☐ Rapid heart beat ☐ Dizzy ☐ Pale ☐ Headache ☐ Lack of coordination ☐ Tiredness ☐ Hungry ☐ Confusion ☐ Seizure ☐ Loss of consciousness ☐ Irritability/Personality changes ☐ Other _____	☐ Increased thirst ☐ Increased urination ☐ Tiredness ☐ Increased appetite ☐ Decreased appetite ☐ Blurred Vision ☐ Headache ☐ Sweet, fruity breath ☐ Dry, itchy skin ☐ Achiness ☐ Stomach pain/nausea/vomiting ☐ Seizure ☐ Loss of consciousness/coma ☐ Other _____

To be completed by Diabetes Team

Physical Condition: ☐ Diabetes Type 1 ☐ Diabetes Type 2 Date of Diagnosis: _____

SECTION I - Routine Management

Blood Sugar (Glucose) Testing

Preferred testing location: ☐ Classroom ☐ Office ☐ Where convenient

Test prior to ☐ Breakfast ☐ Snack ☐ Lunch ☐ Before PE ☐ After PE ☐ Before leaving school

☐ Test when symptomatic

Student can perform own glucose test: ☐ No ☐ Yes, ☐ Independently ☐ Supervised

☐ Record glucose reading and send home to parent/guardian weekly

- **If child's blood sugar is low (< ____), refer to Section II, Low Blood Glucose Reading (Hypoglycemia)**
- **If child's blood sugar is high (> ____), refer to Section III, High Blood Glucose Reading (Hyperglycemia)**

Insulin Administration

Type of Insulin: _____

Preferred administration location: ☐ Classroom ☐ Office ☐ Where convenient

☐ SQ (Use I:C card/chart) ☐ PUMP (All settings programmed into pump)

☐ Prior to Breakfast ☐ Immediately after Breakfast
☐ Prior to Lunch ☐ Immediately after Lunch
☐ Prior to Snack ☐ Immediately after Snack

Student can calculate insulin dosage: ☐ No ☐ Yes, ☐ Independently ☐ Supervised

Student can self-administer insulin: ☐ No ☐ Yes, ☐ Independently ☐ Supervised

☐ **Parent/Guardian MAY transmit changes of therapy, including insulin doses, to school personnel in writing**

Student Name: School Year:

SECTION II - Responding to Low Blood Glucose (BG) Reading (Hypoglycemia)

Preferred testing location: ☐ Classroom ☐ Office ☐ Where convenient

Hypoglycemia level for age: ☐ Under 5 years of age = BG < 90 or 90-110 with symptoms
☐ 5-11 years of age = BG < 80 or 80-100 with symptoms
☐ 12 years and older = BG < 70 or 70-90 with symptoms

Treat with 15 grams of quick carb (4 oz. juice or 3-4 glucose tabs)**:**

☐ Under 5 years, BG < 90 or 90-110 with symptoms
☐ 5-11 years, BG < 80 or 80-100 with symptoms
☐ 12 years and older, BG < 70 or 70-90 with symptoms

Treat with 30 grams of quick carb (8 oz. juice or 6-8 glucose tabs)**:**

☐ Under 5 years, BG < 60
☐ 5-11 years, BG < 55
☐ 12 years and older, BG < 50

Recheck BG and treat every 15 minutes until BG is above hypoglycemic level for age

Severe Low Blood Glucose: Student is unconscious, having a seizure, or having difficulty swallowing

- Stay with student, protect from injury, turn on side
- Do not put anything into the student's mouth
- Appoint someone to call 911 and the family
- Suspend or remove insulin pump (if worn)
- Give Glucagon: ☐ 5-30 lbs, Give 0.3cc or 30 units ☐ 31-50 lbs, Give 0.5 cc or 50 units ☐ 51 + lbs, Give 1.0 cc or 100 units

1.) Inject liquid from syringe into vial to dilute powder
2.) Draw appropriate amount of Glucagon into the syringe
3.) Inject Glucagon into student's upper arm or upper leg muscle
4.) Turn student on side

SECTION III - Responding to High Blood Glucose (BG) Reading (Hyperglycemia)

For BG of ____ - 300: If not meal time - no intervention, return to class

If meal time, give extra insulin at: ☐ Breakfast ☐ Lunch ☐ Snack (Use insulin correction factor card/chart)

For BG of 300+: Have student check ketones when strips are available

Positive Ketones: ☐ **Call parent/guardian** ☐ Give 8-16 oz. of water hourly ☐ No exercise, gym, or recess
☐ If on pump, check infusion set ☐ Recheck ketones at next urination

Negative Ketones: If not meal time - no intervention, return to class

If meal time, give extra insulin at: ☐ Breakfast ☐ Lunch ☐ Snack (Use insulin correction factor card/chart)

If no ketone strips are available: ☐ Treat as Positive Ketones (and request strips from family)

SECTION IV - Food and Misc.

☐ Snack daily at _____ ☐ Snack as needed for low blood sugar ☐ Never withhold food

☐ Never withhold access to water or bathroom ☐ Have 15 grams of quick carb available at site physical activity

For special occasions that involve food: ☐ always contact parent for guidance **OR** ☐ student can self-manage

☐ When out of classroom, student will always travel with buddy

☐ For fieldtrips, always group student with trained school staff member or own parent

_____ _____

Parent/Guardian Signature Date Physician Signature Date

(Void if not signed)

Information transcribed from _____ by _____ on _____
(Ordering Physician or Agency) (RN, Physician, or PA) (Date)