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| DIABETES MEDICAL MANAGEMENT PLAN (School Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| Student's Name:.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_ Diabetes □ Type 1 : □ Type 2 Date of Diagnosis :\_\_\_\_\_  School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_ Homeroom\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Effective Date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CONTACT INFORMATION**  Parent/Guardian #1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Numbers Home\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Pager\_\_\_\_\_\_\_\_\_\_  Parent/Guardian #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Numbers Home\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Pager\_\_\_\_\_\_\_\_\_\_  Diabetes Healthcare Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_ Phone Numbers home \_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell/Pager \_\_\_\_\_\_\_\_\_ |
| **EMERGENCY NOTIFICATION: Notify parents of the following conditions** *(If unable to reach parents, call Diabetes Healthcare Provider listed above)*  a.Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.  b. Blood sugars in excess of mg/dl  c. Positive urine ketones.  d. Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, or altered level of connsciousness. |
| **MEALS/SNACKS**: Student can: D Determine correct portions and number of carbohydrate serving D Calculate carbohydrate grams accurately  Time/Location Food Content and Amount Time/Location Food Content and Amount  □ Breakfast \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Mid-afternoon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Midmorning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Before PE/Activity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ After PE/Activity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If outside food for party or food sampling provided to class \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **BLOOD GLUCOSE MONITORING AT SCHOOL:** □ Yes □ No Type of Meter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If yes, can student ordinarily perform own blood glucose checks? □ Yes □ No Interpret results □ Yes □ No Needs supervision? □ Yes □ No  Time to be performed: □ Before breakfast □ Before PE/Activity Time  □ Midmorning: before snack □ After PE/Activity Time  □ Before breakfast □ Mid-afternoon  □ Dismissal □ As needed for signs/symptoms of low/high blood glucose  Place to be performed: □ Classroom □ Clinic/Health Room □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  OPTIONAL: Target Range for blood glucose: \_\_\_\_\_\_\_\_\_\_\_mg/dl to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Completed by Diabetes Healthcare Provider). |
| **INSULIN INJECTIONS DURING SCHOOL**: □ Yes □ No □ Parent/Guardian elects to give insulin needed at school  If yes, can student: Determine correct dose? □ Yes □ No Draw up correct dose? □ Yes □ No  Give own injection? □ Yes □ No Needs supervision? □ Yes □ No  **Insulin Delivery**: □ Syringe/Vial □ Pen □ Pump (If pump worn, use "Supplemental Information Sheet for Student Wearing an Insulin Pump")  **Standard daily insulin at school**: □ Yes □ No  Type Dose: Time to be given:  \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Calculate insulin dose for carbohydrate intake**: □ Yes □ No Correction dose of insulin for high blood sugar: □ Yes □ No  If yes, use: □ Regular □ Humalog □ Novolog If yes: □ Regular □Humalog □Novolog Time to be given\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_*#* unit(s) per \_\_\_\_\_\_\_\_\_grams Carbohydrate Use Formula: (BG-\_\_\_\_\_\_\_) / \_\_\_\_\_\_\_\_ = Units of insulin**  □Add carbohydrate dose to correction dose If student uses a sliding scale please attach to DMMP. |
| **OTHER ROUTINE DIABETES MEDICATIONS AT SCHOOL:** □ Yes □ No  Name of Medication Dose Time Route Possible Side Effects  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **EXERCISE, SPORTS, AND FIELD TRIPS**  Blood glucose monitoring and snacks as above. Quick access to sugar-free liquids, fast-acting carbohydrates, snacks, and monitoring equipment.  A fast-acting carbohydrate such as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_should be available at the site.  Child should not exercise if blood glucose level is below \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mg/dl OR if\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SUPPLIES TO BE FURNISHED/RESTOCKED BY PARENT/GUARDIAN**: (Agreed-upon locations noted on emergency card/nursing care plan)  □ Blood glucose meter/strips/lancets/lancing device □ Fast-acting carbohydrate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Insulin vials/syringe  □ Ketone testing strips □ Carbohydrate-containing snacks □ Insulin pen/pen needles/cartridges  □ Sharps container for classroom □ Carbohydrate free beverage/snack □ Glucagon Emergency Kit |
| **504 TESTING PERAMATERS:**  **Blood Glucose should be between \_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_ for school tests.** |



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| **MANAGEMENT OF HIGH BLOOD GLUCOSE** (over \_\_\_\_\_\_mg/dl)   |  |  | | --- | --- | | **Usual signs/symptoms for this student:**   * Increased thirst, urination, appetite * Tiredness/sleepiness * Blurred vision * Warm, dry, or flushed skin * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Indicate treatment choices:**   * Sugar-free fluids as tolerated\_\_\_\_\_\_\_\_ mg/dl * Check urine ketones if blood glucose over * Notify parent if urine ketones positive. * May not need snack: call parent * See "Insulin Injections: Correction Dose of Insulin for High Blood Glucose" * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **MANAGEMENT OF VERY HIGH BLOOD GLUCOSE** (over \_\_\_\_\_\_\_\_\_\_\_\_\_. mg/dl)   |  |  | | --- | --- | | **Usual signs/symptoms for this student**   * Nausea/vomiting * Abdominal pain * Rapid, shallow breathing * Extreme thirst * Weakness/muscle aches * Fruity breath odor * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Indicate treatment choices:**   * Carbohydrate-free fluids if tolerated * Check urine for ketones * Notify parents per "Emergency Notification" section * If unable to reach parents, call diabetes care provider * Frequent bathroom privileges * Stay with student and document changes in status * Delay exercise. * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **MANAGEMENT OF LOW BLOOD GLUCOSE** (below \_\_\_\_\_\_\_\_\_\_\_\_\_. mg/dl)   |  |  | | --- | --- | | **Usual signs/symptoms for this child**   * Hunger * Change in personality/behavior * Paleness * Weakness/shakiness * Tiredness/sleepiness * Dizziness/staggering * Headache * Rapid heartbeat * Nausea/loss of appetite * Clamminess/sweating * Blurred vision * Inattention/confusion * Slurred speech * Loss of consciousness * Seizure * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Indicate treatment choices:**  ***If student is awake and able to swallow****,*  *Give \_\_\_\_grams fast-acting carbohydrate such as*:   * 4oz. Fruit juice or non-diet soda or * 3-4 glucose tablets or * Concentrated gel or tube frosting or * 8 oz. Milk or * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Retest BG 10-15minut.es after treatment  Repeat treatment until blood glucose over 80mg/dl  Follow treatment with snack of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  if more than 1 hour till next meal/snack or if going to activity   * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | | --- | | **IMPORTANT!!**  ***If student is unconscious or having a seizure****, presume the student is having a low blood glucose and:*  Call 911 immediately and notify parents.   * Glucagon 1/2 mg or 1 mg (circle desired dose) should be given by trained personnel. * Glucose gel 1 tube can be administered inside cheek and massaged from outside while awaiting or during administration of Glucagon by staff member at scene. * Glucagon/Glucose gel could be used if student has documented low blood sugar and is vomiting or unable to swallow.   Student should be turned on his/her side and maintained in this "recovery" position till fully awake". | |
| **SIGNATURES**  I/we understand that all treatments and procedures may be performed by the student and/or trained unlicensed assistive personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed this information sheet and agree with the indicated instructions. This form will assist the school health personnel in developing a nursing care plan.    Parent's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician's Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School Nurse's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  This document follows the guiding principles outlined by the American Diabetes Association  Revised December 5, 2003 |

Diabetes Medical Management Plan Florida Governors Diabetes Advisory Council Page 2 of 2