Charlotte County Public Schools

Diabetes Medical Management Plan (School Year ____ - ____)

To Be Completed By Licensed Health Care Provider

Student's Name:_________________Date of Birth: _______ ☐Type 1 ☐ Type 2 Date of Diagnosis _______
School Name: ___________________ Grade: ____________ Homeroom _______________________________

CONTACT INFORMATION

Licensed Health Care Provider: ______________________________ Telephone Number: __________________
Other Emergency Contact: ________________________Relationship:____________Tel. Number:____________

SNACKS **Time** **Food Content and amount** **Time** **Food Content and amount**

☐ Mid-Morning _______ ___________________ ☐Before P.E./Activity _____ __________________
☐ Mid-Afternoon _______ ___________________ ☐ After P.E./Activity _____ __________________

BLOOD GLUCOSE MONITORING AT SCHOOL: **At school:** ☐Yes ☐No To ordinarily be performed by student: ☐Yes ☐No
Student has been trained by Health Care Professional? ☐Yes ☐No Type of Meter:
____

Time to be performed: ☐Before Breakfast ☐ Before P.E./Activity Time
☐Mid-Morning: before snack ☐ After P.E./Activity Time
☐Before Lunch ☐ 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 **Student has been trained by Healthcare Professional** ☐Yes ☐No

If yes, can student determine correct dose? ☐Yes ☐ No Draw up correct dose? ☐Yes ☐No **Give own injection?** ☐Yes ☐No

Insulin Delivery: ☐Syringe/Vial ☐Pen ☐Pump (if pump, use "Insulin Pump Medication/Treatment Plan")

Standard daily insulin at school ☐Yes ☐No

Type: Dose: Time to be given:
____ __________ ______________
____ __________ ______________

Calculate Insulin dose for carbohydrate intake: ☐Yes ☐No
If yes, use: ☐Regular ☐Humalog ☐Novolog
_______#Unit(s)per _______grams carbohydrate
☐Add carbohydrate dose to correction dose

Correction dose of insulin for high blood sugar? ☐Yes ☐No
If yes, ☐Regular ☐ Humalog ☐Novolog
Time to be given: _______a.m. _______p.m.
☐Determine dose per sliding scale below:
Blood sugar: _______Insulin Dose ______
Blood sugar: _______Insulin Dose ______
Blood sugar: _______Insulin Dose ______
Blood sugar: _______Insulin Dose ______
☐Use Formula Blood Glucose-_____+ _____=_____units of insulin

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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 indicated.
Easy access to sugar-free liquids, fast-acting carbohydrates, snacks and blood glucose monitoring equipment.
Child should not exercise if blood glucose level is below __________mg/dl **OR** if_____________________________

Usual signs/symptoms for this student	**Indicate treatment choices**
___Change in personality/behavior ___Pallor ___Weak/shaky/tremulous ___Tired/drowsy/fatigued ___Dizzy/staggering walk ___Headache ___Rapid Heartbeat ___Nausea/loss of appetite ___Clammy/sweating ___Blurred vision ___Inattention/confusion ___Slurred speech ___Loss of consciousness ___Seizures ___Other_____________________	**If student is awake and able to swallow** Give_______grams fast-acting carbohydrate such as: ________oz. Fruit juice or non-diet soda or ________glucose tablets or ________concentrated gel or tube frosting or ________oz. Milk or ________other___________________ Retest blood glucose 10-15 minutes after treatment Repeat treatment until blood glucose is over____mg/dl Follow treatment with snack of ___________________ If more than ________hr/min. Until next meal or snack or if going to activity (i.e. PE or recess) Other____ **If student is vomiting or unable to swallow, administer Glucose gel or glucagon (see below for specific instructions.)**

IMPORTANT!

If student is unconscious or having a seizure, presume the student is experiencing a low blood glucose level and call 911 immediately and notify parents/guardians.

___ Glucagon ________mg/dl (injection) should be given by trained personnel

___ Glucose gel 1 tube can be administered inside cheek and massaged from outside while waiting for help to arrive, or during administration of Glucagon by any trained staff member at scene.

Student should be turned on his her side and maintained in this 'recovery" position until fully awake.

Comments:____
____
____
____

Licensed Healthcare Provider Signature:__________________________________Date:_________________________

Licensed Healthcare Provider Name Printed:_______________________________Phone Number_________________

I grant the principal or his/her designee of a licensed nurse (RN/LPN) permission to assist with or perform the administration of each prescribed medication, including insulin either by injection or pump, and treatments/procedures for my child during the school day. This includes when he/she is away from school property for official school events. I have reviewed, understand and agree with the medications/treatments prescribed by the physician/healthcare provider on this form. It is my responsibility to notify the school if there is a change in the medication/treatment plan prior to its expiration date.

Parent/Guardian Signature____ Date: ________________________

Developed from Diabetes Medical Management Plan/Florida Governor's Diabetes Advisory Council. Revised December 5, 2003

Charlotte County Public Schools

Diabetes Medical Management Plan Supplement for Student Wearing Insulin Pump (School Year ______-______)

Student Name: _________________________ Date of Birth: ________________ Pump Brand/Model: ___________________

Pump Resource Person:_________________ Phone: ____________________(see basic diabetes plan for parent phone#)

Child-Lock on? ☐Yes ☐No How long has student worn an insulin pump? ___________________________

Blood Glucose Target Range:____

Student to receive carbohydrate bolus? ☐Yes ☐No

Lunch/snack boluses pre-programmed? ☐Yes ☐No Time(s) to receive bolus _______________________

Insulin correction formula for blood glucose over target: ____

Extra Pump supplies furnished by parent/guardian:

☐infusion sets ☐reservoirs ☐batteries ☐dressings/tape ☐insulin ☐syringes/insulin pen (required)

STUDENT PUMP SKILLS	NEEDS HELP	IF YES, TO BE ASSISTED BY AND COMMENTS:
1. Independently count carbohydrates	1. ☐ Yes ☐No	___________________
2. Give correct bolus for carbohydrates consumed	2. ☐ Yes ☐No	___________________
3. Calculate and administer correction bolus	3. ☐ Yes ☐No	___________________
4. Recognize signs/symptoms of site infection	4. ☐ Yes ☐No	___________________
5. Calculate and set a temporary basal rate	5. ☐ Yes ☐No	___________________
6. Disconnect pump if needed	6. ☐ Yes ☐No	___________________
7. Reconnect pump at infusion set	7. ☐ Yes ☐No	___________________
8. Prepare reservoir and tubing	8. ☐ Yes ☐No	___________________
9. Insert new infusion set	9. ☐ Yes ☐No	___________________
10. Give injection with syringe or pen, if needed	10. ☐ Yes ☐No	___________________
11. Troubleshoot alarms and malfunctions	11. ☐ Yes ☐No	___________________
12. Reprogram basal profiles if needed	12. ☐ Yes ☐No	___________________

MANAGEMENT OF HIGH BLOOD GLUCOSE ***Follow instructions in basic diabetes Medical Management Plan, but In addition:***

If blood glucose over target range____hours after last bolus or carbohydrate intake, student should receive a correction bolus of insulin using formula: Blood glucose - ________ + ________=________units of insulin.

If blood glucose over_____________________________check urine ketones.

1. **If no ketones,** give bolus by pump and recheck in 2 hours.
2. **If ketones present or_________,** give correction bolus as an injection immediately and contact parent/healthcare provider.

If two consecutive blood glucose readings over 250 (2 hrs or more after first bolus given)

1. Call Parent
2. Check urine ketones
3. Give correction bolus as an injection

MANAGEMENT OF LOW BLOOD GLUCOSE: ***Follow instructions in basic Diabetes Medical Management Plan, but in addition:***

If blood glucose recurs without explanation, notify parent/diabetes provider for potential instructions to suspend pump.

If seizure or unresponsiveness occurs:

1. Call 911 (or designate another individual to do so)
2. Treat with Glucagon (see basic diabetes Medical Management Plan)

(Continued on following page)

3. Stop insulin pump by: ☐ Placing in "suspend" or stop mode (see attached copy of manufacturer's instructions)
☐ Disconnecting at pigtail or clip (send pump with EMS to hospital)
☐ Cutting tubing

4. Notify parent
5. If pump was removed, send with EMS to hospital.

Diabetes Medical Management Plan Supplement for Student Wearing Insulin Pump (Continued)

ADDITIONAL TIMES TO CONTACT PARENT ☐ Soreness or redness at infusion site ☐ Detachment of dressing/infusion set out of place ☐ Leakage of insulin Licensed Diabetes Health Care Provider Name:____ _ Licensed Diabetes Healthcare Provider Signature:____ Parent Signature:____ Modified from Governor's Diabetes Council (Revised 2003)	☐ Insulin injection given ☐ Other____ ____ Telephone Number:_______________________________________ Date:____ Date:____