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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/dlc. 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 □ NoTime 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 glucosePlace 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 schoolIf 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 □ NoType Dose: Time to be given:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Calculate insulin dose for carbohydrate intake**: □ Yes □ No Correction dose of insulin for high blood sugar: □ Yes □ NoIf 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 □ NoName 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)

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| **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| **MANAGEMENT OF VERY HIGH BLOOD GLUCOSE** (over \_\_\_\_\_\_\_\_\_\_\_\_\_. mg/dl)

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| **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| **MANAGEMENT OF LOW BLOOD GLUCOSE** (below \_\_\_\_\_\_\_\_\_\_\_\_\_. mg/dl)

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| **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 treatmentRepeat treatment until blood glucose over 80mg/dlFollow treatment with snack of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ if more than 1 hour till next meal/snack or if going to activity* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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". |

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| **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 AssociationRevised December 5, 2003 |

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