DIABETES MEDICAL MANAGEMENT PLAN

Student Name: _____ DOB: _____

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

Long acting insulin: _____ Units: _____ Time to be given at school: _____
Type of insulin (Circle one): Novolog or Humalog or Apidra or other: _____
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
Insulin dosing not to be used for snacks unless this box is checked □
Check blood sugar before P.E. □ Yes □ No
Blood sugar should be ≥ _____ before P.E.

Before School Meal	***Lunch***	***After School Meal***
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 ***Sliding scale is based on correction factor of ____ units/____ mg/dL blood sugar.***	___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 ***Sliding scale is based on correction factor of ____ units/____ mg/dL blood sugar.***	___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 ***Sliding scale is based on correction factor of ____ units/____ mg/dL blood sugar.***

School Nurse (licensed RN) may <u>decrease</u> total insulin dosage.

Student's Level of Independence:

Student can perform own blood glucose checks:	□ No	□ With Supervision	□ Yes
Student can calculate carbohydrates independently:	□ No	□ With Supervision	□ Yes
Student can determine correct amount of insulin:	□ No	□ With Supervision	□ Yes
Student can draw correct dose of insulin:	□ No	□ With Supervision	□ Yes
Student can give own injections:	□ No	□ With Supervision	□ Yes
Student may carry own diabetic supplies (ie: pen/ glucometer):	□ No	□ With Supervision	□ Yes
Student can bolus correctly (for carbohydrates or for correction hyperglycemia) :	□ No	□ With Supervision	□ Yes
Student can troubleshoot alarms and malfunctions:	□ No	□ With Supervision	□ Yes

Student Name:_____ DOB:_____

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 > 80 mg/dL.
If unconscious or having a 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 for ketones if blood sugar > 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. If blood glucose is ≥_____, student will be sent home.

Physician Authorization & Parent Consent for Diabetes Medical Management Plan

My signature below provides authorization for the 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:_____

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

Circle one:
Kaiser (Roseville) Sutter UC Davis Other: _____

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: _____