Calhoun County Public Health Department

School Wellness Program

DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL

Effective Date: _____

Student: _____ **DOB:** _____

_____ **School:** _____

Type of Diabetes: ☐ **Type 1** ☐ **Type 2** **Date of Diagnosis:** _____

☐ Other: _____

Blood Glucose Monitoring

☐ Meter Type: _____ ☐ **Blood glucose target range: _____- mg/dl**

☐ Blood glucose monitoring times: _____

☐ For suspected hypoglycemia ☐ At student's discretion excluding suspected hypoglycemia

☐ No blood glucose monitoring at school ☐ Supervision of monitoring and results

☐ Permission to monitor independently

☐ Assistance with monitoring and results

☐ Check blood glucose 10 to 20 minutes before boarding bus

Diabetes Medication

☐ Insulin at school: ☐ Humalog ☐ Novolog ☐ Apidra ☐ Other: _____

Insulin delivery device: ☐ Syringe and vial ☐ Insulin pen ☐ Insulin pump

Insulin dose for school: _____

Standard lunchtime dose: _____

☐ Meal bolus: _____ units of insulin per _____ grams of carbohydrate

☐ Correction for blood glucose: _____ units of insulin for every _____ md/dl above _____

(Correction bolus can be given with meals or every 3 hours if blood glucose levels are high)

☐ Oral Medication for Diabetes at school:_____

☐ Independent in Insulin Administration ☐ Specific sites to avoid for injections_____

Correction Scale

Blood Glucose Value (mg/dl)	Units of Insulin
Less than 100	
100-150	
151-200	
201-250	
251-300	
301-350	
351-400	
More than 400	

Note: Insulin dose is a total of meal bolus and correction bolus.

☐ Parent/Guardian may adjust insulin doses within the following range: _____

Calhoun County Public Health Department

School Wellness Program

DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL

Food Plan

Greater than ___grams of carbohydrate should be covered with insulin

☐ Meal plan prescribed (see below) ☐ Meal plan variable

Breakfast Time: _____ Morning Snack Time: _____

Lunch Time:_____ Afternoon Snack Time: _____

☐ Plan for pre-activity: _____

☐ Plan for after school activities: _____

☐ Plan for class parties: _____

☐ Extra food allowed: ☐ Parent/guardian's discretion ☐ Student's discretion

Hypoglycemia

Blood Glucose < _____ mg/dl

☐ Self treatment of mild lows ☐ Assistance for all lows

☐ Immediately treat with 15 gm of fast-acting carbohydrate (e.g.; 4 oz juice, 3-4 glucose tabs, 6oz regular soda, 3 tsp glucose gel)

☐ Recheck blood glucose in 15 minutes and repeat 15 gm of carbohydrate if blood glucose remains low.

☐ If more than 1 hour until next meal or snack, student should have another 15 gm of carbohydrate.

☐ If child will be participating in additional exercise or activity before the next meal, provide an additional carbohydrate choice.

☐ If student is using an insulin pump, suspend pump until blood glucose is back in goal range.

Severe Hypoglycemia

If the child is unconscious or having seizures due to low blood glucose, immediately administer injection of: **Glucagon _____ mg (glucagon emergency kit) IM**

- Immediately after administering the Glucagon, turn the student onto their side. Vomiting is a common side effect of Glucagon.
- Notify parent/guardian and EMS per protocol

Hyperglycemia

Blood Glucose > _____ mg/dl

☐ Check ketones when blood glucose > _____ mg/dl or student is sick.

☐ Use Correction Scale insulin orders when blood glucose is _____ mg/dl.

☐ Notify parent immediately of blood glucose > _____ mg/dl or if student is vomiting.

☐ If student is using an insulin pump, follow DKA prevention protocol. If trace ketones, give 8 oz. fluids, if greater than trace to go home for monitoring and treatment.

☐ Independent in Ketone Monitoring ☐ Unlimited bathroom pass.

Special Occasions

☐ Arrange for appropriate monitoring and access to supplies on all field trips.

1. As parent/guardian of _____ , I give permission for this plan to be available for use in my child's school, and for the nurse consultant to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.
2. It is understood by parents and physicians that this plan may be carried out by school personnel other than the school nurse. The school's Registered Nurse is responsible for delegation of this plan to unlicensed school personnel when appropriate.
3. This plan will be reviewed annually and/or whenever the health status or medications change and it is the responsibility of the parent to notify the school nurse of these changes.

Physician Signature:		Date:
Parent Signature:		Date:
School Nurse Signature:		Date:
Student Signature:		Date:

Calhoun County Public Health Department

School Wellness Program

SCHOOL-BASED MANAGEMENT PLAN for the Student with DIABETES

Effective Dates_____ **School Fax Number_____**

STUDENT INFORMATION Photo

Student's Name: _____ Birth Date: _____

Grade: _____ Home Room Teacher: _____

Physical Education Days and Times: _____

Parents: _____ Phone: _____ Pager/Cell: _____

Physician: _____ Phone: _____

TO BE COMPLETED BY THE CHILD'S PHYSICIAN

IF BLOOD SUGAR RESULT IS THIS	PERFORM THIS ACTION
_____	_____
_____	_____
_____	_____

DESIGNATED BLOOD TESTING AREA IN SCHOOL: _____

SNACKS TO BE EATEN IN CLASSROOM: ____Yes ____ No _____

Close by Designated Snack Area_____

COMMENTS: _____

_____

Staff members trained to work with this student:

Name: _____ Position: _____
Name: _____ Position: _____
Name:_____ Position:_____