Stewartville School District #534

(insert picture)

DIABETES MEDICAL MANAGEMENT PLAN

Date of Plan: / / **This plan is valid for the current school year: 20_____**

STUDENT INFORMATION

Name: DOB: / / Grade: School:

DIABETIC INFORMATION

Diagnosed at _____ months/years of age.

Type of Diabetes: ☐ **Type 1** ☐ **Type 2** ☐ **Other: _____**

Desired blood glucose: _____ to _____

Insulin Program ☐ **Continuous Insulin Therapy** ☐ **Injection Insulin Therapy** ☐ **Continuous Glucose Monitoring**

SCHEDULE FOR BLOOD GLUCOSE MONITORING AND INSULING ADMINISTRATION

Morning/Breakfast Insuling Needs:

Before School Check In:

Lunch Insulin Needs:

Afternoon Insulin Needs:

INSULIN CORRECTION SCALE

Name of Insulin: _____ ***List time to use correction scale:***

	BG <	_____	mg/dL -	____	units	_____
BG	_____	to _____	mg/dL -	____	units	_____
BG	_____	to _____	mg/dL -	____	units	_____
BG	**_____**	**to _____**	**mg/dL -**	**0 (goal)**		
BG	_____	to _____	mg/dL +	____	units	
BG	_____	to _____	mg/dL +	____	units	
BG	_____	to _____	mg/dL +	____	units	
	BG>	_____	mg/dL +	____	units	**Parent Signature: _____**
		Ketones moderate or large +		____	units	**Date: _____**

LOW BLOOD GLUCOSE (hypoglycemia)

* Student's usual signs of hypoglycemia: _____
* Student recognizes signs of his/her reaction in its early stages? ☐ Yes ☐ No
* Treatment of Hypoglycemia: If below _____ give _____ glucose tabs or _____ ounces of juice
  If below _____ give _____ glucose tabs or _____ ounces of juice
* Lunch or snack time student may eat: Normal amount of carbs ☐ Yes ☐ No
  Specific amount of carbs ____ *grams of carbs*
* If not lunch or snack time repeat blood sugar in _____ minutes. Repeat treatment as needed.
* If blood glucose levels are below _____, notify parent.
* **EMERGENCY PROTOCOL**
  * **If student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), administer via injection: Glucagon: _____ 1/2 mg _____ 1 mg**
    * **Turn student on their side**
    * **Call Health Services Staff**
    * **Call 911 and parent**
    * **Stay with student**

HIGH BLOOD GLUCOSE (hyperglycemia)

* Student's usual signs of hypoglycemia: _____
* Student recognizes signs of his/her reaction in its early stages? ☐ Yes ☐ No
* Treatment of Hyperglycemia: Give _____ ounces of water or powerade.
* Allow access to bathroom as needed
* Blood glucose above _____ mg/dL, call parent(s)/guardian(s).
* Contact parents and Health Services Staff if blood glucose level is above _____ or has moderate to large amounts of urine ketones.
* **EMERGENCY PROTOCOL**
  * **If student has symptoms of a hyperglycemia emergency, including dry mouth, extreme thirst and/or vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain and increasing sleepiness or lethargy, or depressed level of consciousness:**
    * **CALL 911**
    * **Call Health Services Staff**
    * **Stay with student**

EXERCISE/ACTIVITY CONSIDERATIONS

* Student should **not participate** in exercise of blood glucose level remains **below _____ mg/dL.**
* Consider decreasing insulin dose before exercise.
* Consider eating an extra snack before or during exercise.

STUDENT'S SELF-CARE BLOOD GLUCOSE CHECKING SKILLS

- ☐ Independently checks own blood glucose
- ☐ May check blood glucose with supervision
- ☐ Requires a school nurse or trained diabetes personnel to check blood glucose
- ☐ Uses a smartphone or other monitoring technology to track blood glucose.

CLASSROOM ACCOMMODATIONS

* Unlimited access to drinking water (if a container is needed, parent is to provide)
* Bathroom privileges when medically necessary
* Send child to office with staff/buddy if possible for low blood glucose
* Re-take tests as needed for blood glucose imbalances
* Other: _____

Extra snacks/parties (check all that apply):

- ☐ Child will eat treat(s)
- ☐ Teacher/staff will notify parent prior to activity
- ☐ Schedule extra insulin per pre-arranged plan
- ☐ Treat will be replaced with alternative snack provided by parent
- ☐ Child will eat treat and administer pump insulin bolus per pump calculation

Field Trips:

- ☐ Totally independent
- ☐ Parent/Guardian accompanies child
- ☐ Other:_____

PHYSICIAN'S AUTHORIZATION

OTHER PERTINENT MEDICATION	DOSAGE	TIME	SPECIAL INSTRUCTIONS:

Physician's Signature X:	**Date:** / /
Physician's (Printed Name):	Phone:
Clinic:	Fax:

AUTHORIZATION FOR STAFF ADMINISTRATION OF MEDICATION

I understand that trained school personnel will follow the Diabetes Medical Management Plan as completed by my child's physician, school nurse and myself. Further under the delegation of the LSN/RN, I hereby given mypermission that trained school personnel can administer this emergency medication in the absence of a school nurse or if my child is away from the school on a field trip or other school activity.

Parent/Guardian signature:	**Date:** / /
Health Services Staff signature:	**Date:** / /