DIABETES MEDICAL MANAGEMENT PLAN

Student's Name: _____

Date of Birth: _____ Medical Record #: _____

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

Type of insulin: Novolog or Humalog or Apidra
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-meal
Insulin dosing not to be used for snacks unless this box checked ☐.

Before school meal	*Lunch*	*After school meal*
Insulin dose = _____units	Insulin dose = _____units	Insulin dose = _____units
Insulin dose = _____units/_____grams of carbohydrates	Insulin dose = _____units/_____grams of carbohydrates	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
___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
___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.	*Sliding scale is based on correction factor of ____units/_____ mg/dl blood sugar.*	*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	☐ Yes	
Student can bolus correctly (for carbohydrates or for correction of hyperglycemia)	☐ No	☐ With Supervision	☐ Yes
Student can troubleshoot alarms and malfunctions?	☐ No	☐ Yes	

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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 > 80mg/dl.

If unconscious or having 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 ketones if blood glucose > 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 <u>will be sent home</u>.*

PHYSICIAN'S AUTHORIZATION & PARENT CONSENT
FOR DIABETES MEDICAL MANAGEMENT PLAN

My signature below provides authorization for this 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:** _____

Kaiser (Roseville)   Sutter   UCDavis   Other: _____

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

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:** _____