



# DIABETES MEDICAL MANAGEMENT PLAN

## BLOOD GLUCOSE MONITORING

Target range for blood glucose is \_\_\_\_\_

Routine times to check blood glucose at school are \_\_\_\_\_

Times to do extra blood glucose checks are (*check all that apply*)

- before exercise
- after exercise
- when student exhibits symptoms of hyperglycemia
- when student exhibits signs of hypoglycemia
- other (*explain*) \_\_\_\_\_

- Student can perform own blood glucose checks with supervision.
- Student can perform own blood glucose checks without supervision.
- School personnel must perform blood checks.
- Exceptions: \_\_\_\_\_

Type of blood glucose meter used: \_\_\_\_\_

## FOR THOSE USING INSULIN INJECTIONS

### Lunchtime Dose

- Base dose of insulin to be given is: \_\_\_\_\_ (*name*) \_\_\_\_\_ units
- Flexible dose of insulin to be given is: \_\_\_\_\_ (*name*) \_\_\_\_\_ units/ \_\_\_\_\_ grams of carbohydrate.
- Other insulin to be given is: \_\_\_\_\_ (*name*) \_\_\_\_\_ units

### Insulin Correction ( *Sliding Scale* )

Name of insulin to be given is: \_\_\_\_\_

\_\_\_\_\_ 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

- Student can give own injections.
- Student can give own injections with supervision.
- School personnel must give injections.
  
- Student can determine correct amount of insulin.
- Student can determine correct amount of insulin with supervision.
- School personnel must determine correct amount of insulin.
  
- Student can draw correct dose of insulin
- Student can draw correct dose of insulin with supervision.
- School personnel must draw correct dose of insulin.

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## STUDENTS WITH INSULIN PUMPS

Type of pump: \_\_\_\_\_ Basal rates: \_\_\_\_\_ units/hr. 12 am to \_\_\_\_\_  
 \_\_\_\_\_ units/hr. \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ units/hr. \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ units/hr. \_\_\_\_\_ to \_\_\_\_\_

Type of insulin in pump: \_\_\_\_\_  
 Type of Infusion set: \_\_\_\_\_ Inserting Device Used: \_\_\_\_\_  
 Insulin/ carbohydrate ration: \_\_\_\_\_ Correction factor: \_\_\_\_\_

### *Student Pump Ability/ Skills*

### *Needs Assistance*

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Count carbohydrates                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bolus correct amount for carbohydrates    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and administer corrective bolus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set basal profiles          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set temporary basal rate    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Disconnect pump                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Reconnect pump at infusion set            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prepare reservoir and tubing              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insert infusion set                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Troubleshoot alarms and malfunctions      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS

Type of medication: \_\_\_\_\_ Time taken: \_\_\_\_\_  
 Other medications: \_\_\_\_\_ Time taken: \_\_\_\_\_

## MEALS AND SNACKS EATEN AT SCHOOL

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Student is independent in carbohydrate calculations & management      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Student requires assistance in carbohydrate calculations & management | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| School personnel must do carbohydrate calculations & management       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

<i>Meal/Snack</i>	<i>Time</i>	<i>Food Content/ Amount</i>
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Other times to give snacks	_____	_____

- |                       |                              |                             |
|-----------------------|------------------------------|-----------------------------|
| Snack before exercise | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Snack after exercise  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Preferred snack foods: \_\_\_\_\_  
 Foods to avoid, if any: \_\_\_\_\_

Instructions for when food is provided to the class (e.g., class parties): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# DIABETES MEDICAL MANAGEMENT PLAN

## EXERCISE AND SPORTS

A fast acting carbohydrate such as \_\_\_\_\_ should be available at the site of exercise or sports.

Restrictions on activity, if any: \_\_\_\_\_

Student should not exercise if blood glucose level is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl.

### HYPOGLYCEMIA (LOW BLOOD SUGAR)

Usual symptoms of hypoglycemia: \_\_\_\_\_

Treatment of hypoglycemia: \_\_\_\_\_

\_\_\_\_\_ (Dosage) Glucagon should be given intramuscularly (IM) if the student is unconscious, having a seizure (convulsion), or unable to swallow. Site for Glucagon injection may be arm, thigh, or buttock.

**If glucagon is required, administer it simultaneously while calling 911 and the parents/guardians.**

### HYPERGLYCEMIA (HIGH BLOOD SUGAR)

Usual symptoms of hyperglycemia: \_\_\_\_\_

Treatment of hyperglycemia: \_\_\_\_\_

\*\*\*\*\***Call parent if blood sugar above \_\_\_\_\_ mg/dl.**

### Supplies to be kept at school (*Provided by parent or guardian*)

- \_\_\_\_\_ Blood glucose meter, blood glucose test strips, batteries for meter
- \_\_\_\_\_ Lancet device, lancets, gloves, etc.
- \_\_\_\_\_ Fast acting source of glucose
- \_\_\_\_\_ Insulin vials and syringe
- \_\_\_\_\_ Insulin vials and syringes
- \_\_\_\_\_ Carbohydrate containing snack
- \_\_\_\_\_ Insulin pump and supplies
- \_\_\_\_\_ Insulin pen, pen needles, insulin cartridges
- \_\_\_\_\_ Urine/blood ketone strips
- \_\_\_\_\_ Glucagon emergency kit

# DIABETES MEDICAL MANAGEMENT PLAN

## SIGNATURE PAGE

### PHYSICIAN'S AUTHORIZATION FOR DIABETES MEDICAL MANAGEMENT PLAN:

*Please initial and check all boxes that apply*

- \_\_\_\_\_ Parent/ Guardian is authorized to make necessary changes or adjustments to this Diabetes Medical Management Plan, except as follows: \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_ Parent/ Guardian is not authorized to make changes or adjustments to this Diabetes Medical Management Plan.
- \_\_\_\_\_ Parent/ Guardian must submit authorized changes or adjustments to this Diabetes Medical Management Plan in writing to school personnel.
- \_\_\_\_\_ School personnel will fax changes or adjustments to my office using fax number below.
- \_\_\_\_\_ I have prescribed this Diabetes Medical Management Plan.

My signature below provides authorization for this Diabetes Medical Management Plan. I understand that all procedures will be implemented in accordance with Education Code section 49423.5. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by a school nurse. We (I) also understand that the administration of insulin may not be administered by unlicensed personnel in a nonemergency situation, and that state law limits this activity to nurses, family members or students themselves. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

- I have instructed \_\_\_\_\_ in the proper way to use his/her  
(Child's Name) Medications. It is my professional opinion that \_\_\_\_\_ should be  
(Child's Name) allowed to carry and use that medication by him/herself. Physician's initials \_\_\_\_\_
- I request that a school nurse provide me with a copy of the completed Diabetes Medical Management Plan.

**Physician's Name** \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Address** \_\_\_\_\_ **City/ Zip** \_\_\_\_\_

**Physician's Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

# DIABETES MEDICAL MANAGEMENT PLAN

## PARENT CONSENT FOR DIABETES MEDICAL MANAGEMENT PLAN

We (I), the undersigned, the parent(s)/ guardian(s) of the above named child, request that this Diabetes Medical Management Plan, and any modifications thereto, be implemented while our (my) child is at school or attending a school-related event on or off campus. We (I) understand that the services will be administered to our (my) child in accordance with Education Code section 49423.5. We (I) understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by a school nurse. We (I) also understand that the administration of insulin may not be administered by unlicensed personnel in a nonemergency situation, and that state law limits this activity to nurses, family members or students themselves.

We (I) agree to:

1. Provide the necessary supplies and equipment.
2. Notify the school nurse if there is a change in pupil health status or attending physician.
3. Notify the school nurse immediately and provide new written consent for any changes in the physician's orders.

I understand that I will be provided with a copy of my child's completed Diabetes Medical Management Plan.

We (I) authorize the school nurse to communicate with the physician when necessary.

We (I) also consent to the release of information contained in the Diabetes Medical Management Plan to Auburn Union School District staff and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. This consent also extends to other adults who may need to know the information contained in this Diabetes Medical Management Plan to maintain my child's health and safety.

We (I) agree that school personnel implementing this Diabetes Medical Management Plan are authorized to make modifications to the Plan pursuant to written direction from the student's legal parent/guardian. However, we (I) understand that any written parent/guardian consent for modifications that require physician authorization, as noted above, will not be implemented unless written physician authorization is also submitted to school personnel. **All modifications to the Diabetes Medical Management Plan MUST be in written form.** The requests for modification received in writing must include the date, the modification, and signatures of both the parent/guardian and the school employee receiving them, and a written physician authorization if required. These changes will be attached to this Diabetes Medical Management Plan and will be maintained in the student/s health record.

Student's Parent/Guardian (please print)	Student's Parent/Guardian (signature)	Date
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Student's Parent/Guardian (please print)	Student's Parent/Guardian (signature)	Date
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**Reviewed by School Nurse** \_\_\_\_\_  
(Signature) Date

**Reviewed by Principal** \_\_\_\_\_  
(Signature) Date