St. Lucie County Public Schools

Diabetes Medical Management Plan for School Year 20___ - 20___

Student's Name:		DOB:	Date:
Date Diagnosed:		Diabetes Type:	
School:		Grade:	Home Room:
Parent/Guardian #1:	Home #:	Cell #:	Work #:
Parent/Guardian #2:	Home #:	Cell #:	Work #:
Parent/Guardian's E-mail Address:			
Diabetes Healthcare Provider:		Phone:	Fax:

STUDENT'S SELF-MANAGEMENT SKILLS	NO SUPERVISION NEEDED	NEEDS SUPERVISION
Performs and Interprets Blood Glucose Tests	☐	☐
Calculates Carbohydrate Grams	☐	☐
Determines Insulin Dose for Carbohydrate Intake	☐	☐
Determines Correction Dose of Insulin for High Blood Glucose	☐	☐
Student allowed to carry diabetes supplies, determine insulin dose and self-administer insulin	☐	

Students who require no supervision are allowed to carry diabetes supplies and self-administer insulin with written parental and physician authorization, according to Florida Statute. Students who need supervision will be monitored in the school clinic.

TESTING BLOOD GLUCOSE AT SCHOOL

Test Blood Glucose before administering insulin and as needed for signs/symptoms of high/low blood glucose.

Additional Blood Glucose Testing at school: ☐ Before Breakfast ☐ Before Lunch ☐ Before snack ☐ Before dismissal ☐ other OR ▶ ☐ No

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No CGM Model: _____ ALARM High_____ Low _____
☐ Use CGM result to treat ☐ Check blood glucose if symptoms or expectations do not match readings

INSULIN ADMINISTRATION

Insulin **correction** for ***high blood glucose*** at school, indicate times: ☐ Before Breakfast ☐ After Breakfast ☐ Before Lunch ☐ After Lunch ☐ Other time_____

☐ Only use correction dose if blood glucose level is above _____

May **NOT** repeat insulin **correction dose** within _____ hours of a correction dose for high blood glucose.

Correction Dose: Blood glucose minus _____ divided by _____ equals units of insulin to be administered.

Type of Insulin at school:	☐ Humalog	☐ Novolog	☐ Apid	☐ NPH	☐ Lant	☐ Levemir	☐ Tresiba	☐ Other:

Method of Insulin delivery at school:	☐ **Pen/ syringe**	☐ **Insulin Pump: Insulin Pump will calculate insulin dose.** If pump fails, use **pen/syringe** to administer insulin per sliding scale or correction dose formula. Indication of possible pump failure is **BG > 250 and moderate or large ketones.** **If BG is below ____mg/dl, suspend pump and refer to hypoglycemia management**

DAILY INSULIN DOSAGE AT SCHOOL

☐ Before Breakfast ☐ After Breakfast Insulin type: Number of units

☐ Before Lunch ☐ After Lunch Insulin type: Number of units

HIGH BLOOD SUGAR CORRECTION DOSE – USE INSULIN SLIDING SCALE

Blood sugar _____ to _____	Insulin Dose = _____ units	Blood sugar _____ to _____	Insulin Dose = _____ units
Blood sugar _____ to _____	Insulin Dose = _____ units	Blood sugar _____ to _____	Insulin Dose = _____ units
Blood sugar _____ to _____	Insulin Dose = _____ units	Blood sugar _____ to _____	Insulin Dose = _____ units

CARBOHYDRATE INSULIN DOSE

Insulin for ***carbohydrates*** eaten at school:

☐ Before Breakfast ☐ After Breakfast **Give one unit of insulin per _____ grams of carbs eaten.**

☐ Before Lunch ☐ After Lunch **Give one unit of insulin per _____ grams of carbs eaten.**

LOW BLOOD SUGAR (HYPO-GLYCEMIA) – TEST BLOOD SUGAR TO CONFIRM

Student's Usual Signs and Symptoms			Does student recognize signs of **LOW** blood sugar? ☐ Yes ☐ No			
Low Blood Sugar:	☐ Hungry	☐ Weak/Shaky	☐ Headache	☐ Dizziness	☐ Inattention/confusion	
Very Low Blood Sugar:	☐ Nausea or loss of appetite	☐ Slurred speech	☐ Clamminess or sweating	☐ Blurred vision	☐ Loss of consciousness	☐ Other ____

Management of Low Blood Glucose (below _____ mg/dl)

1. If student is awake and able to swallow: give 15 grams fast-acting carbohydrates such as:
   4 oz. fruit juice or non-diet soda or 3-4 glucose tablets or concentrated gel or tube frosting or 8 oz. skim milk
   or Other: _____
2. Retest blood glucose 10-15 minutes after treatment. Student remains in clinic during treatment.
3. Repeat the above treatment until blood glucose is over _____ mg/dl.
4. Follow treatment with snack of _____ grams of carbohydrates plus a protein if more than one hour until next meal/snack or if going to activity.
5. Notify parent when blood glucose is below _____ mg/dl.
6. Delay exercise if blood glucose is below _____ mg/dl.

If student is unconscious or having a seizure, call 911 immediately and notify parents. Position student on side if possible. If wearing an insulin pump, place pump in suspend/stop mode or disconnect/cut tubing.

☐ **Glucose gel:** One tube administered inside cheek and massaged from outside while waiting or during administration of Glucagon.

☐ **Glucagon:** _____ mg administered (subcutaneous or intramuscular) by trained personnel. Glucagon is stored in _____.

HIGH BLOOD SUGAR (HYPER-GLYCEMIA)

Student's Usual Signs and Symptoms	Does the student recognize signs of **HIGH** blood sugar? ☐ Yes ☐ No				
High Blood Sugar:	☐ Increased thirst and/or urination	☐ Tired/drowsy	☐ Blurred vision	☐ Warm, dry or flushed skin	☐ Weakness/ muscle aches
Very High Blood Sugar:	☐ Nausea/ vomiting	☐ Abdominal pain	☐ Extreme thirst	☐ Fruity breath odor	☐ Other:

Management of High Blood Glucose (BG) (over _____ mg/dl)

1. If greater than ___ hours since last correction dose, and BG over _____ mg/dl, administer insulin per **correction dose**.
2. Give water or other calorie-free liquids as tolerated and allow frequent bathroom privileges.
3. Check **ketones** if blood glucose over _____ mg/dl.
4. Notify parent if **ketones** positive and/or glucose over _____ mg/dl.

In addition to steps above for management of high blood glucose, also follow steps below for very high blood glucose over _____ mg/dl.

5. If unable to reach parents, call diabetes care provider.
6. If unable to reach parents or physician stay with student and document changes in status. Call 911 for labored breathing, very weak, confused or unconscious.
7. Retest blood glucose in _____ hours if BG above _____ mg/dl.
8. Delay exercise if blood glucose is above _____ mg/dl.

If glucometer reads "hi" or "high" administer ____ units of insulin and refer to Management of High Blood Glucose above.

Physician's Signature: _____ **Date:** _____

Physician's Printed Name and Phone Number: _____

I, parent/guardian, understand that it is my responsibility to provide and maintain an adequate supply of all necessary diabetic supplies including, but not limited to: insulin, glucagon, glucose tablets/gel, blood glucometer, ketone strips, glucose testing strips, lancets, alcohol wipes, snacks, and water. Expired medication will NOT be administered. I/we understand that all treatments and procedures may be performed by the student and/or trained unlicensed assistive personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed this information and agree with the indicated instructions. I hereby give permission to the school nurse to share information with appropriate school staff as he/she determines appropriate for my child's health and safety, and to contact the above health care provider for information relevant to the prescribed treatment.

Parent/Guardian's Signature: _____ **Date:** _____

Principal's Signature: _____ **Date:** _____

Health Paraprofessional's Signature: _____ **Date:** _____

Registered Nurse's Signature: _____ **Date:** _____