Student Name: School Year:

School-based Medical Management Plan for the Student with Diabetes

To be completed by Parent/Guardian

Student Name: ____________________ Birthdate: ______________ Grade: __________

Address: ____

Mother/Guardian: ____________________ Phone: (home) ______________ (cell) ______________

Father/Guardian: ____________________ Phone: (home) ______________ (cell) ______________

Other Emergency Contact: ______________ Phone: ______________ Relationship: ______________

Symptoms: (check student's usual symptoms)

Hypoglycemia (low blood sugar)	Hyperglycemia (high blood sugar)
☐ Shaky ☐ Weak ☐ Sweaty ☐ Rapid heart beat ☐ Dizzy ☐ Pale ☐ Headache ☐ Lack of coordination ☐ Tiredness ☐ Hungry ☐ Confusion ☐ Seizure ☐ Loss of consciousness ☐ Irritability/Personality changes ☐ Other ______________________	☐ Increased thirst ☐ Increased urination ☐ Tiredness ☐ Increased appetite ☐ Decreased appetite ☐ Blurred Vision ☐ Headache ☐ Sweet, fruity breath ☐ Dry, itchy skin ☐ Achiness ☐ Stomach pain/nausea/vomiting ☐ Seizure ☐ Loss of consciousness/coma ☐ Other ______________________

To be completed by Diabetes Team

Physical Condition: ☐ Diabetes Type 1 ☐ Diabetes Type 2 Date of Diagnosis: ______________

SECTION I - Routine Management

Blood Sugar (Glucose) Testing

Preferred testing location: ☐ Classroom ☐ Office ☐ Where convenient

Test prior to ☐ Breakfast ☐ Snack ☐ Lunch ☐ Before PE ☐ After PE ☐ Before leaving school

☐ Test when symptomatic

Student can perform own glucose test: ☐ No ☐ Yes, ☐ Independently ☐ Supervised

☐ Record glucose reading and send home to parent/guardian weekly

- **If blood sugar is low (< ___ or < ___ with symptoms), see Section II, Low Blood Glucose Reading (Hypoglycemia)**
- **If blood sugar is high (> ____), refer to Section III, High Blood Glucose Reading (Hyperglycemia)**

Insulin Administration

Type of Insulin: ______________________

Preferred administration location: ☐ Classroom ☐ Office ☐ Where convenient

☐ SQ (Use Insulin dosing card/chart) ☐ PUMP (All settings programmed into pump)

☐ Prior to Breakfast ☐ Immediately after Breakfast
☐ Prior to Lunch ☐ Immediately after Lunch
☐ Prior to Snack ☐ Immediately after Snack

Student can calculate insulin dosage: ☐ No ☐ Yes, ☐ Independently ☐ Supervised

☐ Family will provide carb counts to school staff daily

Student can self-administer insulin: ☐ No ☐ Yes, ☐ Independently ☐ Supervised

Location of Supplies: ☐ In Office ☐ In Classroom ☐ With Student ☐ Other ______________________

SECTION II - Responding to Low Blood Glucose (BG) Reading (Hypoglycemia)

Student Name: School Year:

Hypoglycemia Level: BG less than _____ or less than _____ with symptoms

First:

Treat with 15 grams of quick carb (4 oz. juice or 3-4 glucose tabs)

OR Treat with 30 grams of quick carb (8 oz. juice or 6-8 glucose tabs) if blood glucose less than _____

Recheck BG and treat every 15 minutes until BG is above ______

☐ If > 1 hour before a meal, give a snack of protein and complex carbohydrates
☐ If mealtime and no difficulty swallowing, monitor and allow student to eat lunch while waiting to recheck BG
☐ Once BG is in safe range and student has finished eating lunch, give insulin to cover **lunch carbs only**

Severe Low Blood Glucose: Student is unconscious, having a seizure, or having difficulty swallowing

- Stay with student, protect from injury, turn on side
- Do not put anything into the student's mouth
- Appoint someone to call 911 and the family
- Suspend or remove insulin pump (if worn)
- Give Glucagon: ☐ 5-30 lbs, Give 0.3cc or 30 units ☐ 31-50 lbs, Give 0.5 cc or 50 units ☐ 51 + lbs, Give 1.0 cc or 100 units

1.) Inject liquid from syringe into vial to dilute powder
2.) Draw appropriate amount of Glucagon into the syringe
3.) Inject Glucagon into student's upper arm or upper leg muscle
4.) Turn student on side

SECTION III - Responding to High Blood Glucose (BG) Reading (Hyperglycemia)

For BG of ____ - 300: If not meal time - no intervention, offer water, return to class if feeling well

If meal time, give insulin to correct blood sugar at: ☐ Breakfast ☐ Lunch ☐ Snack (see Section I, Insulin Administration)

For BG of 300+: Have student check ketones when strips are available

If meal time, give insulin to correct blood sugar at: ☐ Breakfast ☐ Lunch ☐ Snack (see Section I, Insulin Administration)

Positive Ketones: ☐ **Call parent/guardian** (trace or Small-attempt to flush > Moderate-parent pickup immediately) ☐ Give 8-16 oz. of water hourly ☐ No exercise, gym, or recess ☐ If on pump, check infusion set ☐ Recheck ketones at next urination ☐ Call EMS if severe abdominal pain, nausea, vomiting, or lethargy presents

Negative Ketones: If not meal time - give water, encourage exercise, return to class if feeling well

If no ketone strips are available: ☐ Treat as Positive Ketones (and request strips from family)

SECTION IV - Food and Misc.

☐ Snack daily at _______________ ☐ Snack as needed for low blood sugar ☐ Never withhold food
☐ Never withhold access to water or bathroom ☐ Have 15 grams of quick carb available at site physical activity

For special occasions that involve food: ☐ always contact parent for guidance **OR** ☐ student can self-manage

☐ Out of classroom, student will always travel with buddy ☐ Fieldtrips - student will be with trained school staff or own parent
☐ A plan for access to food during lockdowns will be developed by family and school staff, and appropriately implemented

All care provided will be recorded and documentation sent home to parent weekly or ___________________

_______________________________________ _______________________________________

Parent/Guardian Signature Date Physician Signature Date
(Void if not signed)

Information transcribed from __________________________ by __________________________ on ____________
(Ordering Physician or Agency) (RN, Physician, or PA) (Date)