## DIABETES MEDICAL MANAGEMENT & TREATMENT PLAN FOR SCHOOL

Instructions: Page one completed by parent/guardian.

Student's Name:						
Date of Birth:	Date Diagnosed:					
Transportation to/from school:Bus	Car	Drives	Walk	Daycare	Other	
	Contact Inf	ormation				
Parent/guardian's name(s):						
Home Phone (	Cell Phone(s)					
	(mother)					
Additional contact in an EMERGENCY Physician's Name:	Name/relationship/phone(s)					
Glucose tabletsInst Meter and supplies (	ant Glucose	nol wipes, batt	on Kit _ ery)		3	

Permission is given for blood glucose testing by the school nurse or designee, using equipment provided by the student's parent/guardian. It is understood when the school nurse or designee is not available for blood glucose testing, the parent/guardian or "911" will be notified depending on the state of the crisis.

\_Nurse or designee to perform blood glucose testing OR supervise procedure performed by student

\*\*\*\_\_\_\_Student is independent and may test blood glucose levels without supervision \*\*\* \_\_\_\_Student is independent and may administer insulin without supervision

\*\*\*The responsibility of physician ordered student self-monitoring blood glucose and/or self-administration of insulin during school hours shall be determined by the school nurse following assessment of skill and knowledge level. Demonstration by student of specific responsibilities include, but not limited to, correct use of blood glucose meter, understanding of symptoms and treatment of high and low blood sugar levels, knowledge of selfadministration of insulin including time(s) and disposal of supplies. The student will agree to seek assistance from school nurse as needed. \*\*\*

1		ent in self-administration of insulin ar lf-administration of medicine.	nd blood glucose testing YesNo			
Student's Signature	Date	School Nurse's Signature	Date			
Authorization to Release Medical Information I hereby give authorization to release/receive information regarding my child						
		physician/clinic) and y of health care services to my child wh				

Student Name: \_

## Authorized Orders Completed by Medical Provider

## HYPOGLYCEMIA (LOW BLOOD SUGAR)

Common signs of <u>low blood sugar</u> may include, but not limited to, shakiness, sweatiness, hunger, or headache. **<u>Recommended treatment</u>** for low blood sugar (<\_\_\_\_\_) is:

- 1. Give 15 grams of **fast acting** carbohydrate (i.e.: <sup>1</sup>/<sub>2</sub> cup fruit juice <u>or</u> 3-4 glucose tablets—<u>NO PROTEIN</u> <u>and NO FAT until blood sugar is above 70</u>).
- 2. If meal time is greater than an hour away, then protein and some additional carbohydrates can be added (i.e.: crackers & cheese)
- GLUCAGON: Glucagon is reserved for low glucose levels associated with loss of consciousness or convulsions. If weight < 20 kg, administer 0.5 mg IM. If weight >20 kg, administer 1.0 mg. IM (Weight\_\_\_\_). Call 911 following injection.

Additional comments\_\_\_\_\_

## HYPERGLYCEMIA (HIGH BLOOD SUGAR)

Signs of <u>high blood sugar</u> may include, but not limited to: nausea, headache, increased urination, and/or thirst. <u>Recommended treatment</u> for high blood sugar (>\_\_\_\_\_\_) is:

- 1. Correction formula: Current blood sugar \_\_\_\_ minus (-) \_\_\_\_ divided by \_\_\_\_. Use when blood sugar is above \_\_\_\_ Correction insulin must be spaced 2 hours apart.
- 2. Check for **ketones** if blood glucose > 240. If moderate to large ketones, call medical provider for instructions and notify parent/guardian.
- 3. Parent/guardian to provide Regular Insulin at school for moderate to large urine ketones as directed by provider.

Additional comments\_\_\_\_\_

<b>Authorized Prescriber's Instructions:</b>
Targeted Blood Glucose levelto    Test blood glucose level as needed and:   hours after eating before meals/snacks before going home
unit of NovoLog/Humalog/Apidra for everygrams of carbohydrate for meals/snacks with hours between doses. Exception:
<b>Correction formula:</b> Current blood sugar minus (-) divided by Use when blood sugar is above Correction insulin must be spaced 2 hours apart.
Student is independent and may test blood glucose without supervision. Student is independent and may administer insulin without supervision.
Additional Comments/Instructions:
Authorized Prescriber's SignaturePhoneDate    Prescriber's Address
Nurse SignatureDate:
School Address ***ALL changes in insulin doses administered during the school day require written instruction from the authorized prescriber.***