Elim Christian School

DIABETES MEDICAL MANAGEMENT PLAN

_____ School Year

_____ D.O.B.
Student Name

_____ _____ _____
Parent/Guardian Phone Cell

_____ _____ _____
Parent/Guardian Phone Cell

_____ _____ _____
Physician Phone Fax

Target Blood Glucose Range:_____

Contact **parent** for blood glucose below_____ or above_____

Contact **physician** for blood glucose below_____ or above _____

Checking Blood Glucose Level

(check all that apply)

Upon arrival_____

After Lunch_____ 2hrs after correction dose_____ Before PE_____

After PE_____ Before Dismissal_____ Other:_____

As needed for signs/symptoms of low or high blood glucose____

As needed for signs/symptoms of illnes_____

Brand/Model of blood glucose monitor:_____

Note: The fingertip should be used to check blood glucose level if hypoglycemia is suspected.

Continuous Glucose Monitor (CGM) Brand/Model:_____

Note: Confirm CGm results with blood glucose meter check before taking action on sensor blood glucose level.

Hypoglycemia Treatment

Student's usual hypoglycemic symptoms:_____

_____

_____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose is less than _____, give quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 10-15 minutes and repeat treatment if blood glucose level is less than_____.

Additional treatment_____.

If the student is unable to eat or drink, is unconscious, unresponsive or having seizure activity give

Glucagon: 1mg 1/2mg SC IM Site for injection: arm thigh other:_____

Then call 911 and the parent/guardian

Diabetes Medical Management Plan, Continued

Hyperglycemia Treatment

Student's usual symptoms of hyperglycemia:_____

_____

_____

Check urine for ketones every _____hours for blood glucose levels above _____

Give extra water and/or non-sugar containing drinks (not fruit juices):_____ounces per hour.

Notify parent/guardian of onset of hyperglycemia

If student exhibits dry mouth, extreme thirst, nausea, vomiting, severe abdominal pain, shortness of breath, chest pain, lethargy or depressed level of consciousness call 911.

Insulin Therapy

Insulin delivery device: syringe insulin pen insulin pump

Name of insulin_____ Dose:_____ Time:_____

Sliding Scale

Other Medication

Blood glucose_____to_____mg/dL give _____units

Blood glucose_____to_____mg/dL give _____units

Blood glucose_____to_____mg/dL give _____units

Blood glucose_____to_____mg/dL give _____units

Fixed Therapy

Name of insulin_____

Give _____units before lunch daily.

Give_____units before snack daily.

Adjustable Therapy

Name of insulin_____

Lunch: 1 unit of insulin per _____ grams of carbohydrate

Snack: 1 unit of insulin per _____ grams of carbohydrate

Parental Authorization to Adjust Insulin Dose

(please circle)

YES NO Parent/guardian authorization should be obtained before administering correction dose.

YES NO Parent/guardian are authorized to increase/decrease sliding scale +/-_____units of insulin.

YES NO Parent/guardian are authorized to increase/decrease fixed dose +/-_____units of insulin.

Additional Insulin Pump Information

(check all that apply))

Basal rate during school:_____ Type of infusion set_____

_____ For suspected pump failure: suspend or remove pump and give insulin by syringe or pen

_____ For infusion site failure: insert new infusion set and/or replace reservoir

_____ For blood glucose greater than _____mg/dL that has not decreased within _____hours after correction consider pump or infusion site failure and notify parent/guardian.

Physical Activity and Sports

Avoid physical activity when blood glucose is greater than _____mg/dL or if urine ketones are moderate to large.

A quick-acting source of glucose must be available at the site of physical education activities and sports.

_____ _____

Physician/Healthcare Provider Signature **Date**

Diabetes Medical Management Plan, Continued

Authorization Page

All supplies, medications and monitors are to be supplied to Elim by the parent/guardian. Parent will be notifed when replenishments are needed by the nursing office.

This Diabetes Medical Management Plan has been approved by _____
physician/health care provider

I, as parent/guardian give permission to the school nurse or other qualified health care professional to perform and carry-out the diabetes care tasks as outlined in the Diabetic Medical Management Plan. I also consent to the release of the information contained in this plan to all school staff members and other adults who are responsible for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

_____

Parent Signature Date

_____

Parent Signature Date