1745 West Grand
Haysville, Kansas 67060
Phone: 316-554-2200
Fax #: 316-554-2230

Beth Schutte, R.N.
District School Nurse

DIABETES MEDICAL MANAGEMENT PLAN

Dear Parents or Guardian:

This plan should be completed by the student's physician and parents/guardian. Please have the physician to give guidelines on hypoglycemia and hyperglycemia, so that the school staff will be clear on what is to be done. Please indicate at what level of blood sugar you would like to be notified.

Please have the physician complete the attached form "Medical Statement for Student Requiring Special Meals Due to Disability", so that the school can make diet modifications. Federal regulations requires the school to receive written instructions from appropriate medical authority before the school can modify your child's meals.

Each school year this plan must be completed by the student's physician and parents/guardian. If you have any questions or concerns, please call the Nurse or Health Aide in your child's school.

Thank you,
Beth Schutte, R.N.
District School Nurse for Haysville Schools

1745 West Grand
Haysville, Kansas 67060
Phone: 316-554-2200
Fax #: 316-554-2230

USD 261
HAYSVILLE

Medical Management for Diabetes

To be completed by parents/school nurse and health care provider

A non-nurse school employee may be designated and trained by the school nurse to provide the service(s). If school nurse or designee are unavailable to provide requested Prescribed Special Health Care Services, 911 will be secured if an emergency should arise.

Diagnosis – ☐ **Type 1 Diabetes** ☐ **Type 2 Diabetes** ☐ **Pre Diabetes/Dysmetabolic Syndrome**

Diabetes Care Plan for ____________ School ____________ Effective Date ______
(Name of Student)

Date of Birth ________ Age of Onset ______ Grade _____ Homeroom Teacher ____________

Contact Information –

Parent/Guardian #1 ____________ Address ____________

Telephone – Home ____________ Work ____________ Cell Phone ____________

Parent/Guardian #2 ____________ Address ____________

Telephone – Home ____________ Work ____________ Cell Phone ____________

Student's Doctor/Health Care Provider ____________ Phone ____________

Nurse Educator ____________ Phone ____________

Parent designee ____________ Relationship ____________

Telephone – Home ____________ Work ____________ Cell Phone ____________

Hospital Choice ____________ **Known Allergies** ____________

Blood Glucose Monitoring

___ **No, will be managed at home.**

Target range for blood glucose: 70 mg/dl to 180 mg/dl ____________ (Type of blood glucose meter used)

Times to test must be checked below:

Usual times to check blood glucose per parent

___ mid-morning ___ before exercise/PE ___ when student exhibits symptoms of hyperglycemia

___ pre-lunch ___ after exercise ___ when student exhibits symptoms of hypoglycemia

___ mid-afternoon ___ other (explain): ____________

Can student perform own blood glucose tests? _____ Yes _____ No Exceptions: significant hypoglycemia

Routine Pre-meal Insulin – ____ No, will be managed at home.

Supplemental Insulin on next page.

BREAKFAST – give

_______units **OR**

_______units/_______grams of carbohydrates **OR**

_______units/_______calories

Type (circled) novolog humalog apidra

LUNCH – give

_______units **OR**

_______units/_______grams of carbohydrates **OR**

_______units/_______calories

Type (circled) novolog humalog apidra

Parent may direct insulin dose variation between _____ and _____ units without further orders.

Other (e.g., pre-lunch supplemental): ____________

Home insulin – Type ____________ Dose ____________ Frequency ____________

Can student give own injections? ___ Yes ___ No

Can student determine correct amount of insulin? ___ Yes ___ No

Can student draw correct dose of insulin? ___ Yes ___ No

For Students with Insulin Pumps –

Type of pump ____________________

Insulin/carbohydrate ratio ____________________

Correction factor ____________________

Is student competent regarding pump? ___Yes ___No

Can student effectively troubleshoot problems (e.g. ketosis, pump malfunction)? ___Yes ___No

Comments ____________________

Change site after a bolus within 60 to 90 minutes IF –
ketones do not resolve or blood glucose does not decrease

For Students Taking Oral Diabetes Medications – Medication ____________________

Time(s) ______________ Side Effects ____________________

Other Medications ____________________

Time(s) ______________ Side Effects ____________________

Meals and Snacks Eaten at School –

Is the student in high school? If so, can the high school student be responsible for meals and snacks during school? ___Yes ___No

	Time	Food content / amount
Breakfast	________	____________________
A.M. snack	________	optional ____________________
Lunch	________	____________________
P.M. snack	________	optional ____________________

Other times to give snacks and content / amount ____________________

For Hypoglycemia – ***When blood glucose is below*** ____70__________

Common symptoms _shaky, sweaty, hungry, lethargic, irritable____________________

____

Oral Treatment/Amount – 15-20 grams of **quick-acting carbohydrate** such as ½ c. juice, 1 c. milk, 4 glucose tabs, 6 oz. soda, 15 grams glucose gel

OTHER if not on insulin a snack may be sufficient____________________

Recheck Blood Glucose 15 minutes following oral treatment. If blood glucose is still below 70, may repeat oral treatment and recheck blood glucose again in 15 minutes.

* **If blood glucose is still below 70,** repeat oral treatment and notify a parent or parent designee to pick up the student and care for him/her until blood glucose has been above 90 for at least 1 ½ hours.
* **If blood glucose is above 70,** follow with a protein snack. Student may return to class if he/she is not experiencing any symptoms of hypoglycemia.

Glucagon should be given if the student is unconscious, having a seizure, or is unable to swallow.

Glucagon Dose _______ 1 unit (1mg) _______ 1/2 unit (1/2 mg)

- **Give Glucagon** (School Nurse will administer Glucagon IM; designated trained school personnel will administer Glucagon SubQ).
- **Call 911**
- **Notify parent or parent-designee (see page 1)**

For Hyperglycemia – When blood glucose is above ______________ (always check for ketones)

NO exercise if any ketones or if blood glucose is > ________________.

When supplemental insulin IS or IS NOT ordered –

A. If blood glucose is 250 or above with ketones, encourage water.
B. If blood glucose is 250-300 without ketones, encourage water and mild exercise.
C. If blood glucose is >300, with or without ketones, encourage water.
D. If blood glucose is >350 encourage water. Recheck in 60 minutes. If level is still elevated, parent or parent-designees will be notified to pick student up from school and care for him/her until level is below 300.

When Supplemental and/or Pre-meal correction insulin is given at school –

Correction factor: Type of Insulin: ______________
1 unit will decrease the blood glucose approximately ________**mg. This child's target blood glucose is:** __________.

Pre-meal correction insulin for hyperglycemia may be given when the blood glucose is greater than _______mg/dl.

Supplemental insulin for hyperglycemia may be given when Blood Glucose is > 250 with ketones or if greater than 300 mg/dl. Up to _______units SubQ may be given.

When supplemental insulin is given, blood glucose should always be rechecked in 2 hours OR in 60 minutes if **large ketones** or **if blood glucose is greater than 400**.

Supplemental insulin may be repeated **if blood glucose is greater than 250 mg/dl in 120 minutes** or **ketones persist.**

Children with diabetes need unrestricted access to the restroom and fluids and snacks available as needed. **We also encourage minimal disruption to class and activity periods.**

****

Signatures –

____ ____________________
Physician / ARNP / PA Signature Date

____
Printed Name of Physician / ARNP / PA

____
Supervising Physician (required for ARNP or PA)

Office Phone # ____________Office Fax # Glucose reports: Updated orders:

Parent/Guardian Signature: ____

Any amendments to this Medical Management for Diabetes must be in writing.

A new request must be completed annually AND when any amendment occurs.

Revised August 2011