Madison County Schools **School: _____** **School Year: _____**

MANAGEMENT PLAN FOR STUDENTS WITH DIABETES

SECTION I – Parent (Please Print)

Student Name: DOB: Weight:

Medications Taken At Home:

Transportation To and From School: AM: PM:

Allergies:

Parent Name	Cell Phone	Work Phone

Emergency Contact Name	Relationship to Student	Cell Phone	Work Phone

Physician: Phone Number:

Preferred Hospital in Case of Emergency:

Do you have any Religious Objections to Medical Treatment: ☐ Yes ☐ No

If "yes", describe:

Section II - Physician:

SNACK	Times snacks are to be eaten: _____ Snacks = _____ gm. carbs
MEAL PLAN	1. Diet prescribed by physician: _____ grams of carbohydrates per meal. 2. Copy of diet orders to cafeteria? YES _____ NO _____ (Check one)
BLOOD GLUCOSE TESTING	1. Blood glucose target range: _____ mg./dl to _____ mg./dl 2. Check blood glucose: (Check all that apply.) _____ before meals _____ 1-2 hours after lunch _____ before snacks/class parties _____ student feels "low" or "ill" _____ before getting on bus _____ before P.E. _____ before school dismissal _____ Before driving: Target Range: _____
	3. Student will complete blood glucose testing: (Check one) _____ independently _____ independently with adult supervision _____ with assistance from an adult 4. Glucometer will be kept: _____ (location)
INSULIN (School ***Prescriber/Parent Authorization Form*** required for each medication.)	1. Student receives insulin by: Injection _____ Insulin pump _____ (Check one) 2. Insulin type: _____ 3. Insulin dose based on "carb counting"? YES _____ NO _____ (Ck. one) 4. If so, give _____ units insulin per _____ grams carbs eaten CORRECTION FORMULA: When BG is >_____ mg/dl, calculate: BLOOD SUGAR - _____ /_____ and add that # units to meal bolus dose **OR** See Sliding Scale Orders . 5. If not, insulin order is as follows: _____ 6. Insulin bolus dosage calculation: _____ Student calculates dose independently _____ Student calculates dose independently with adult supervision Dose calculated with assistance of or by an adult 7. Insulin administration: _____ Student administers insulin independently _____ Student administers insulin independently with adult supervision _____ Insulin administered with assistance of or by an adult 8. Student has a(n) _____ (brand) insulin pump 9. Insulin taken at home: Type: Dose: / Time: /
KETONES	1. Student to check □ urine □ blood for ketones when blood glucose ≥ _____mg/dl 2. Limitations when ketones present? □ Yes □ No If "yes", please list: _____ _____

DIABETES EMERGENCY ACTION PLAN

Note: In cases of <u>any</u> health concern regarding diabetic students, please observe the following precautions:
(1) Notify nurse to come to classroom, OR
(2) Have <u>adult</u> accompany student to nurse's office AND
(3) Notify nurse that student is being sent to office

IF YOU SEE THIS…	**DO THIS…**
Student exhibiting signs of **LOW** blood sugar: • shaky • irritable • sweating • • Other:	1. Check blood glucose (BG) 2. If blood glucose < _____ mg/dl, student will eat a 15 gm CHO snack & recheck BG in fifteen minutes. 3. If BG recheck is still < _____ mg/dl, repeat 15 gm CHO snack. If BG recheck is at target, eat meal or snack w/protein source. 4. If > 30 minutes to mealtime and/or there is no Improvement, call parent.
Student confused and/or unable to follow simple verbal commands.	1. Check blood glucose if not checked previously 2. Administer glucose paste or cake icing gel to inside of cheeks
Student becomes unconscious, despite using glucose paste or gel. (***School Medication Provider/Parent Authorization*** form required for each medication to be administered in the school setting.)	1. Glucagon ordered? YES _____ No _____ (Ck. one.) 2. If ordered, administer glucagon IM Dose - 0.5 mg. or 1 mg. (circle one) . Place student on his/her side. 3. If glucagon not ordered, place student in side - lying position and call 9-1-1 4.. Call parent / guardian 5. Report to EMS personnel
Student exhibiting signs of **HIGH** blood sugar: • thirsty • drowsy • nauseated • urinating frequently • Other:	1. Check blood glucose 2. Administer insulin *if ordered by physician)* 3. Have student drink at least 16 ounces of water 4. If blood glucose is > _____ ml/dl, student will check urine for ketones 5. Recheck blood glucose in minutes
Blood glucose remains elevated at time of re-check and urine **ketones are NOT** present.	1. Call parent 2. Encourage student to continue to drink water 3. Encourage student to do mild exercise such as "hall-walking" with supervision
If blood glucose > _____ and **ketones ARE** present: If blood glucose > and ketones >	1. Restrict student from P.E. and Recess 2. Encourage fluid intake (water) 3. Call parent /emergency contact 4. **Student needs to be picked up from school**
Student begins to vomit or have diarrhea with or without ketones present.	1. Call parents / emergency contact to pick up student 2. Refer for emergent or urgent medical evaluation

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.
I give permission for the release of my child's medical information, in the event of an emergency.

Physician Signature	Date	Nurse Signature	Date
Parent Signature	Date	Staff Signature	Date

FOR SCHOOL NURSE USE ONLY

Medication	Self-Carry?	Self-Administer?	Expiration	Location of Medication

July 2014