



Manatee County School Health Services

Diabetic Medical Management Plan



Student Name: _____

School Year: _____

<p>Glucose Monitoring at School: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Testing performed: <input type="checkbox"/> Independent <input type="checkbox"/> w/ supervision</p> <p>Testing supplies carried by student: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Testing performed in: <input type="checkbox"/> Clinic <input type="checkbox"/> Classroom <input type="checkbox"/> Other</p> <p>Time to be performed: <input type="checkbox"/> Mid-morning <input type="checkbox"/> Before/After Meal <input type="checkbox"/> Mid-afternoon <input type="checkbox"/> Before Dismissal <input type="checkbox"/> Before/After PE/Activity <input type="checkbox"/> PRN for symptoms of low/high blood sugar</p> <p>Time of Daily Classroom Snack: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon</p> <p>Classroom parties: <input type="checkbox"/> Student to eat treats <input type="checkbox"/> Replacement (parent provided)</p> <p>Continuous Glucose Monitor Brand/Model: _____</p> <p>Alarms set for (low): _____ (High): _____ Note: Confirm CGM results with blood glucose meter before taking action on sensor blood glucose level. With S/S hypoglycemia, check fingertip Blood glucose level regardless of CGM.</p>	<p>Insulin Therapy at School:</p> <p>Type of Insulin: _____</p> <p>Insulin Dosage: _____</p> <p>Insulin Delivery: <input type="checkbox"/> syringe <input type="checkbox"/> pen <input type="checkbox"/> pump <input type="checkbox"/> Independent <input type="checkbox"/> w/supervision <input type="checkbox"/> Clinic Staff</p> <p>Student can: Determine correct dose <input type="checkbox"/> Y <input type="checkbox"/> N Draw up correct dose <input type="checkbox"/> Y <input type="checkbox"/> N Give own injection <input type="checkbox"/> Y <input type="checkbox"/> N Needs supervision <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Target Range/Number: _____</p> <p>Insulin/Carb Ratio: _____ unit(s) per _____ grams</p> <p>Correction Factor: _____ unit(s) per _____ mg/dl (points)</p> <p>Sliding Scale Coverage: _____ to _____ = _____ units _____ to _____ = _____ units _____ to _____ = _____ units</p> <p>Parents/guardian are authorized to increase or decrease correction dose scale within +/- _____ units of insulin (not greater than 2 units maximum).</p>
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<p>Hypoglycemia (low blood sugar)</p> <p>Symptoms of Hypoglycemia All or some of the following symptoms may occur: <input type="checkbox"/> Headache/dizziness/blurred vision <input type="checkbox"/> Weakness/shakiness/tremors <input type="checkbox"/> Irritability/personality changes <input type="checkbox"/> Drowsy/fatigue <input type="checkbox"/> Loss of consciousness</p>	<p>(Blood Sugar < _____ Range)</p> <p>Treatment of Hypoglycemia (indicate treatment choices): <input type="checkbox"/> Approximately 15 grams of carbohydrates i.e. juice, glucose tabs, glucose gel tube, syrup, cake icing tube <input type="checkbox"/> After treatment of 15 grams of carb wait 15 min and retest blood sugar <input type="checkbox"/> If blood glucose is <70 repeat treatment of 15g of carbs. If >70 then return to regular activities w/ protein snack or meal</p>
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Emergency Glucagon

Administer Glucagon D0.5mg D1mg if child is unconscious, having a seizure or unable to eat / drink fluids to bring up severe low blood sugar.

Call 911 and parent(s) immediately.

Call 911 immediately for severe low blood glucose/unconscious state when Glucagon is not available/ provided by parent.

Insulin Pump Only:

Pump failure: Parent to perform site change Student to perform site change

<p>Hyperglycemia (high blood sugar)</p> <p>Symptoms of Hyperglycemia <input type="checkbox"/> Increased thirst <input type="checkbox"/> Tired/drowsy/less energy <input type="checkbox"/> Blurred vision <input type="checkbox"/> Warm, dry, or flushed skin <input type="checkbox"/> Fruity breath (odor) <input type="checkbox"/> Lack of concentration</p>	<p>(Blood Sugar > _____ Range)</p> <p>Treatment of Hyperglycemia <input type="checkbox"/> Sugar free fluids <input type="checkbox"/> May not need snack <input type="checkbox"/> Frequent bathroom breaks <input type="checkbox"/> Check urine for ketones if Blood Glucose > _____</p> <p>For abdominal pain / vomiting, and/or moderate to large ketones or blood sugars > _____. Notify Parent for pick-up. This is a potential emergency situation. If unable to contact or pick-up, 911 will be called.</p>
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Supplies / Field Trips

All diabetic supplies are to be provided to the school/student by the parent/guardian and taken with the student for field trips.

Physician Signature: _____ Date: _____

Print Physician Name: _____ ICD Code: _____

Physician Address: _____ Phone: _____

Parent/Legal Guardian Signature: _____ Date: _____

Phone: _____ School Nurse Signature: _____

Date: _____

Insulin vials Expire 28 Days After Opening Per Manufacturer