Manatee County School Health Services
Diabetic Medical Management Plan

Student Name: _____ **School Year:** _____

Glucose Monitoring at School: ____Yes ___No

Testing performed:

___Independent ___w/ supervision

Testing supplies carried by student:

___Yes____No

Testing performed in:

____Clinic_____Classroom_____Other

Time to be performed:

____Mid-morning ____Before/After Meal

____Mid-afternoon ____Before Dismissal

____Before/After PE/Activity

____PRN for symptoms of low/high blood sugar

Time of Daily Classroom Snack:

____Morning ____Afternoon

Classroom parties:

____Student to eat treats

____Replacement (parent provided)

Continuous Glucose Monitor Brand/Model: _____

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.

Insulin Therapy at School:

Type of Insulin: _____

Insulin Dosage: _____

Insulin Delivery: ____ syringe ____ pen ____ pump

___Independent _____w/supervision ____ Clinic Staff

Student can:

Determine correct dose___Y ___N Draw up correct dose___Y____N

Give own injection ___Y ____N Needs supervision____Y____N

Target Range/Number: _____

Insulin/Carb Ratio:_____unit(s) per_____grams

Correction Factor:_____unit(s) per _____mg/dl (points)

Sliding Scale Coverage:_____to_____=_____units

_____to_____=_____units

_____to_____= _____units

_____to_____=_____units

Parents/guardian are authorized to increase or decrease correction dose scale within +/-_____units of insulin (not greater than 2 units maximum).

Hypoglycemia (low blood sugar) **(Blood Sugar <_____Range)**

Symptoms of Hypoglycemia

All or some of the following symptoms may occur:

____Headache/dizziness/blurred vision

____Weakness/shakiness/tremors

____Irritability/personality changes

____Drowsy/fatigue

____Loss of consciousness

Treatment of Hypoglycemia

(indicate treatment choices):

____Approximately 15 grams of carbohydrates i.e. juice, glucose tabs, glucose gel tube, syrup, cake icing tube

____After treatment of 15 grams of carb wait 15 min and retest blood sugar

____If blood glucose is **<70** repeat treatment of 15g of carbs. If **>70** then return to regular activities w/ protein snack or meal

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**

Hyperglycemia (high blood sugar) **(Blood Sugar > Range)**

Symptoms of Hyperglycemia

____Increased thirst

____Tired/drowsy/less energy

____Blurred vision

____Warm, dry, or flushed skin

____Fruity breath (odor)

____Lack of concentration

Treatment of Hyperglycemia

____Sugar free fluids

____May not need snack

____Frequent bathroom breaks

___Check urine for ketones if Blood Glucose > _____

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.

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