School Year: _____

Health Services Department
Diabetic Medical Management & Emergency Plan
Manejo Médico Diabético y Plan de Emergencia

Student: _____ DOB: ___/___/_____ ID#_____ Grade _____

Diagnosis: **Type I** **Type II** **Other: _____**

Year of Diagnosis: _____

PARENTS TO PROVIDE SUPPLIES FOR PROCEDURES/*LOS PADRES DEBEN PROPORCIONAR SUMINISTROS PARA LOS PROCEDIMIENTOS*:

- **Test blood glucose before meals and as needed for signs/symptoms of hypoglycemia or hyperglycemia.** *Medir la glucosa en sangre antes de las comidas y según sea necesario para detectar signos / síntomas de hipoglucemia o hiperglucemia.*
- **Reminder: if the student has a CGM device, CGM monitoring will only be used as a supplementary and will not replace finger stick glucose monitoring as needed.** ***Recordatorio:*** *si el estudiante tiene un dispositivo CGM, el monitoreo de CGM solo se usará como un suplemento y no reemplazará el monitoreo de glucosa por punción en el dedo según sea necesario.*

TO BE COMPLETED BY THE PARENT/*COMPLETAR POR EL PADRE*:

Parents/Guardians please respond to the following questions based on your records and knowledge of the student.
Los padres / tutores respondan a las siguientes preguntas basadas en sus registros y conocimiento del estudiante.

- **External devices/***Dispositivos externos*:
  1. **Would you like the campus nurse, health assistant, or any staff member to have access to continuous glucose monitor readings?** *¿Le gustaría que la enfermera del campus, el asistente de salud o cualquier miembro del personal tengan acceso a lecturas continuas del monitor de glucosa?* **Yes**/*Sí* ☐ **No**/*No* ☐
     a. **If yes, please attach the CGM Parent release form**/*En caso afirmativo, adjunte el formulario de autorización para padres de CGM.*

I the parent/guardian of_____request medication and procedures be administered to my child. I will notify the school nurse immediately if the health status of my child changes, I change physicians or emergency contact information, or the procedure is canceled or changes in any way. Information concerning my child's diabetes health management may be shared with/obtained from the diabetes health care providers. I understand that prescribed in-school medication or procedures may be administered by a school nurse, health assistant, or a non-health professional designee of the principal.

Yo, el padre / tutor de_____ solicito que se administren medicamentos y procedimientos a mi hijo. Notificaré a la enfermera de la escuela inmediatamente si el estado de salud de mi hijo cambia, cambio de médico o información de contacto de emergencia, o el procedimiento se cancela o cambia de alguna manera. La información sobre el manejo de la salud de la diabetes de mi hijo se puede compartir con/obtener de los proveedores de atención médica para la diabetes. Yo entiendo que los medicamentos o procedimientos recetados en la escuela pueden ser administrados por una enfermera escolar, un asistente de salud o un profesional de la salud designado por el director.

Signature/*Firma*: _____ **Relationship**/*Relación*: _____ **Date**/*Fecha*: _____
Phone/*Teléfono* (primary/*primario*): _____ **Phone** (secondary/*secundario*): _____

TO BE COMPLETED BY THE PHYSICIAN:

1. Does this student have physician permission to provide self-care? Yes ☐ No ☐
2. This student has been provided instruction/supervision and is capable of doing self-glucose monitoring and his/ her own insulin injections/insulin pump care, including using universal precautions and proper disposal of sharps. Yes ☐ No ☐
3. The student may perform safe glucose monitoring and/or insulin injections/pump care in the: ☐ clinic ☐cafeteria
4. Does this student need the supervision of a designated adult? Yes ☐ No ☐
5. Does this student have an insulin pump? Yes ☐ No ☐

a. If yes, please attach the student's pump guidelines.

6. Does this student have a continuous glucose monitor (ex. Dexcom, freestyle)? Yes ☐ No ☐

Insulin *is given SQ prior to mealtime (within 30 minutes prior to eating a meal) based on the following guidelines*

Pre-lunch dosage: _____ units Humalog *plus the following sliding scale insulin as indicated by blood glucose level*

Blood glucose below_____= no additional insulin
Blood glucose from_____to_____= unit(s) Regular/Humalog insulin SQ
Blood glucose from_____to_____= unit(s) Regular/Humalog insulin SQ
Blood glucose from_____to_____= unit(s) Regular/Humalog insulin SQ
Blood glucose over_____= unit(s) Regular/Humalog insulin SQ
(Notify parent if blood glucose is over _____)

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Meal Plan: The Constant Carbohydrate Diet emphasizes consistency in the number of grams of carbohydrates eaten from day to day at each meal or snack. Proteins and fats are "free foods" in that they have minimal effect on the blood glucose level. The child and parent can choose the carbohydrate product that they wish to use for meals or snacks. The parent will update the meal plan when changed.

Breakfast_____grams at _____(time).
Mid AM snack_____grams at _____(time).
Lunch_____grams at _____(time).
Mid PM snack_____grams at _____(time).

GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

1. **If glucose is BELOW_____: (hypoglycemia or low blood sugar)**
   - A. Give the child 15 grams of carbohydrate (CHO). i.e.: 6 lifesavers 6 ounces of regular soda 4 ounces of juice 3 – 4 glucose tabs
   - B. Allow the child to rest for 10 – 15 minutes, and retest glucose.
   - C. If symptoms persist (or blood glucose remains below_____), repeat CHO.
   - D. Notify parents of persistent low blood glucose.

   * If it is within 60 minutes before lunch, allow the child to eat the meal or snack.

2. **If blood glucose is BELOW_____and the child is unconscious or seizing:**
   - A. Call emergency medical services.
   - B. Rub a small amount of glucose gel (or cake frosting) on the child's gums and oral mucosa. If available, inject Glucagon_____mg. SQ.
   - C. Notify the parent.

3. **If blood glucose is FROM_____to_____: Follow usual meal plan and activities (**unless otherwise directed by sliding scale for insulin administration.)

4. **If blood glucose is OVER_____:**
   - A. If within 30 minutes prior to lunch, nurse or trained personnel is to be called if the student is unable to administer a correction dose of insulin per the student's sliding scale orders.
   - B. Student checks urine ketones.

     <u>If Ketones are negative or small</u>
     - Encourage water until ketones are negative.

     <u>If Ketones are moderate or large:</u>
     - Student should remain in the clinic for monitoring.
     - Notify parent for pick up.
     - Give 1-2 glasses of water every hour.
     - If the student remains at school, retest glucose and ketones every 2-3 hours or until ketones are negative.
   - C. Student should not participate in PE or other forms of exercise if blood sugar is above 250 and ketones are present.
   - D. **Emergency procedures**: **If a student develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath, call 911, the nurse, and the parents.**

Physician signature:_____ Date: _____

Clinic /facility: _____ Phone:_____ Fax:_____

Clinical Dietitian: _____ Phone:_____

****Attach Special Diet Request Form****