# Bourbonnais Elementary Schools

District No. 53 • 280 W. John Casey Road • Bourbonnais, IL 60914 • (815) 929-5285 • Fax (815) 839-8074
Nurse's Office

## Diabetes Medical Management Plan

This plan should be completed by the student's personal diabetes health care team, including physician and parents/guardian. It should be reviewed with relevant school staff and kept in a place that is easily accessible.

Date of Plan: ________________ This plan is valid for the current school year 20___ - 20___

Student's Name: ____________________________________ Date of Birth: ____________

Date of Diabetes Diagnosis: ________________ Type (1, 2, other): ____________________

School: ________________________________ Grade: ______

### CONTACT INFORMATION

Mother/Guardian: ____________________________________________________________

Address: ____________________________________________________________________

Telephone: Home _________________ Work __________________ Cell _______________

Email: ______________________________________________________________________

Father/Guardian: _____________________________________________________________

Address: ____________________________________________________________________

Telephone: Home _________________ Work __________________ Cell _______________

Email: ______________________________________________________________________

Student's Physician: __________________________________________________________

Address: ____________________________________________________________________

Telephone: __________________________________________________________________

Other Emergency Contacts:

Name: ____________________________ Relationship to Student: _____________________

Telephone: Home _________________ Work __________________ Cell _______________

## CHECKING BLOOD GLUCOSE

Target range: ___________________________

Check blood glucose level at these times (mark appropriate times):

_____ Before lunch
_____ After lunch ___ hours
_____ Before PE
_____ After PE
_____ Before am snack
_____ Before pm snack
_____ 2 hours after correction
_____ Before dismissal
_____ As needed for signs/symptoms of low or high glucose or symptoms of illness
_____ Other: ___________________________________________________________

**Student's self-care blood glucose checking skills** (mark appropriate statement):

_____ Independently checks own blood glucose

_____ May check blood glucose with supervision

_____ Requires school nurse or trained diabetes personnel to check blood glucose

## HYPOGLYCEMIA TREATMENT

Student's usual symptoms of hypoglycemia: ___________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

If exhibiting symptoms of hypoglycemia, OR if blood glucose is less than _________ mg/dl, give a quick acting glucose product equal to __________ grams of carbohydrate.

Recheck blood glucose in 10-15 minutes and repeat treatment if blood glucose level is less than _____ mg/dl.

Additional or other treatment: _________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

## HYPOGLYCEMIA TREATMENT (Continued)

Call parent if sugar is below ______ mg/dl.

Follow physical activity and sports orders on page 7.

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
  - Glucagon: _____ 1mg _____ ½ mg Route: _____SC _____IM
  - Site for glucagon injection: ____ arm ____ thigh ____ other: ________________
  - Call 911 and student's parent/guardian

## HYPERGLYCEMIA TREATMENT

Student's usual symptoms of hyperglycemia: ________________________________________

________________________________________________________________________________

________________________________________________________________________________

Check ___ urine ___ blood for ketones every _______ hours when blood glucose levels are above _______mg/dl.

For blood glucose greater than ____ mg/dl AND at least ____ hours since last insulin dose, give correction dose of insulin (see "correction dose" section).

For insulin pump users: see additional information for student with insulin pump.

Give extra water and/or non-sugar containing drinks (not fruit juices): ____ ounces per hour.

Call parent if sugar is over ______ mg/dl.

Additional treatment for hyperglycemia and positive ketone results: _______________________

________________________________________________________________________________

________________________________________________________________________________

Follow physical activity and sports orders on page 7.

- If student has symptoms of hyperglycemia emergency, including dry mouth, extreme thirst, nausea, vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: **Call 911**, student's parents/guardian and school nurse.

**INSULIN THERAPY**

Insulin delivery device: _____ syringe _____ insulin pen _____ insulin pump

**Type of insulin therapy at school:**

_____ Adjustable Insulin Therapy
_____ Fixed Insulin Therapy
_____ No insulin

**Adjustable Insulin Therapy**

**Carbohydrate Coverage/Correction Dose:**

Name of insulin: ________________________________

**Insulin-to-Carbohydrate Coverage:**

Lunch: 1 unit of insulin per ________ grams of carbohydrate

Snack: 1 unit of insulin per ________ grams of carbohydrate

**Correction Dose:**

Correction Dose Scale (sliding scale):

Blood glucose _____ to _____ mg/dL give _____ units
Blood glucose _____ to _____ mg/dL give _____ units
Blood glucose _____ to _____ mg/dL give _____ units
Blood glucose _____ to _____ mg/dL give _____ units

**When to give insulin:**

Lunch:
_____ Carbohydrate coverage only
_____ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose
_____ Other ________________________________

Snack:
_____ No coverage for snack
_____ Carbohydrate coverage only
_____ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose
_____ Other ________________________________

**Fixed Insulin Therapy**

Name of insulin: ______________________________

_____ Units of insulin given pre-lunch daily
_____ Units of insulin given pre-snack daily
_____ Other ______________________________________________

**Parental Authorization to Adjust Insulin Dose** (mark appropriate statements):

_____ Parents/guardian authorization should be obtained before administering a correction dose.

_____ Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.

_____ Parents/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: ____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate.

_____ Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

**Student's self-care insulin administration skills** (mark appropriate statement):

_____ Independently calculates and gives own injections

_____ May calculate/give own injections with supervision

_____ Requires school nurse or trained diabetes personnel to calculate/give injections

**ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP**

Brand/Model of pump: ____________________________
Type of insulin in pump: ____________________________

_____ For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or insusion site failure. Notify parents/guardian.

_____ For infusion site failure: insert new infusion set and/or replace reservoir.

_____ For suspected pump failure: suspend or remove pump and give insulin by syringe or pen.

**Physical Activity**

_____ May disconnect pump for sports activities

~~_____ Set a temporary basal rate: _____% temporary basal for _____ hours~~

_____ Suspend pump use

**Student's self-care pump skills** (mark appropriate statements):

_____ Count carbohydrates

_____ Bolus correct amount for carbohydrates consumed

_____ Calculate and administer correction bolus

_____ Calculate and set basal profiles

_____ Calculate and set temporary basal rates

_____ Change batteries

_____ Disconnect pump

_____ Reconnect pump to infusion set

_____ Prepare reservoir and tubing

_____ Insert infusion set

_____ Troubleshoot alarms and malfunctions

**OTHER DIABETES MEDICAIONS**

Name: ______________________ Dose: __________ Route: __________ Time: _____

Name: ______________________ Dose: __________ Route: __________ Time: _____

| MEAL PLAN | Time | Carbohydrate Content (grams) |
|---|---|---|
| Mid-morning snack | __________ | ________ to ________ |
| Lunch | __________ | ________ to ________ |
| Mid-afternoon snack | __________ | ________ to ________ |

Other times to give snacks and content/amount: ______________________________

______________________________________________________________

Instructions for when food is provided to the class (e.g., as part of a class party, food sampling event, class project, etc.): ______________________________

______________________________________________________________

______________________________________________________________

Special event/party food permitted: _____ Parents/guardian discretion
_____ Student discretion

**Student's self-care nutrition skills** (mark appropriate statement):

_____ Independently counts carbohydrates

_____ May count carbohydrates with supervision

_____ Requires school nurse or trained diabetes personnel to count carbohydrates

## PHYSICAL ACTIVITY AND SPORTS

A quick-acting source of glucose such as glucose tabs and/or sugar-containing juice must be available at the site of physical education activities or sports.

Student should eat:
_____ 15 grams of carbohydrates
_____ 30 grams of carbohydrates
_____ other: _____

_____ before vigorous physical activity
_____ every 30 minutes during physical activity
_____ after vigour physical activity
_____ other: ______________________________

If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

(Additional information for student with insulin pump is in the insulin section on page 5.)

## DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian. Keep DMMP/emergency card with school/teacher emergency backpack.

_____ Continue to follow orders contained in this DMMP.

_____ Additional insulin orders as follows: ______________________________

______________________________

_____ Other: ______________________________

**Other instructions or information:** ______________________________

______________________________________________

______________________________________________

## SIGNATURES

This Diabetes Medical Management Plan has been approved by:

______________________________________________

Student's Physician/Health Care Provider signature Date

I, (parent/guardian) ______________________ give permission to the School nurse or another qualified health care professional or trained diabetes personnel of (school) ______________________ to perform and carry out the diabetes care tasks as outlined in (student) ______________________'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

______________________________________________

Student's Parent/Guardian signature Date

Plan acknowledged and received by:

______________________________________________

Student's Parent/Guardian signature Date

______________________________________________

Student's Parent/Guardian signature Date

______________________________________________

School Nurse/Other Qualified Health Care Personnel Date