LEON COUNTY SCHOOLS
DIABETES MEDICAL MANAGEMENT PLAN & NURSING CARE PLAN
(School Year ____________-_____________) Plan Effective Date(s):____________________

Student's Name: ______________________________________ Date of Birth: ____________________

Date of Diabetes Diagnosis: ____________________ ☐Type 1 ☐Type 2

School Name: _____________________ School phone number: _________________ School Nurse: ________________

Grade _________ Homeroom ______________________ Independent Management of Diabetes ☐ Yes ☐ No

CONTACT INFORMATION

Parent/Guardian #1: ___________________________ Phone Numbers: Home ________Work__________Cell/Pager ____________

Parent/Guardian #2: ___________________________ Phone Numbers: Home_________ Work_________ Cell/Pager ____________

Diabetes Healthcare Provider________________________________ Phone Number:____

Other Emergency Contact________________________Relationship:______ Phone Number: Home _________Work/Cell/Pager________

MEAL PLAN TYPE: ☐ Carb insulin/Ratio ☐ Consistent Carbohydrate: Meal Range: _______grams **to** _______grams

Student's self care nutrition skills: Snack Range: _______grams **to** _______grams

☐ Independently counts carbohydrates ☐ May count carbohydrates with supervision

☐ Requires school nurse/UAP diabetes personnel to count carbohydrates

Meal Plan (meals/snacks child to have)**:**

"X" To Select	Meal	Time
	Breakfast	
	Mid-morning snack	

"X" To Select	Meal	Time
	Lunch	
	Mid-afternoon snack	

Instructions for when food is provided to the class (e.g., as part of class party or other event): _____________________
____

BLOOD GLUCOSE MONITORING AT SCHOOL: ☐ Yes ☐ No ☐ School personnel not responsible for testing/monitoring, **but supplies are to be available**

Blood Glucose test to be performed in school clinic unless otherwise noted: ____________________________________

Student's self care blood glucose checking skills:

☐ Independently checks own blood glucose ☐ May check blood glucose with supervision

☐ Requires school nurse/UAP diabetes personnel to check blood glucose

☐ Uses a CGM (continuous glucose monitor) &/or smart-phone to track blood glucose values

Time to be performed:

- ☐ Before breakfast
- ☐ Midmorning: before snack
- ☐ Before Lunch
- ☐ Mid-afternoon
- ✖ As needed for signs/symptoms of low/high blood glucose
- ☐ After PE/Activity Time
- ☐ 2-hours after a correction bolus
- ☐ Before Dismissal
- ☐ Before PE/Activity Time **(give snack if ≤ ________mg/dL to bring blood glucose to ≥ 100mg/dL)**

ADDITIONAL INFORMATION FOR STUDENT WITH CGM (CONTINUOUS GLUCOSE MONITOR)**:**

The student should be escorted to the nurse/aid if the CGM alarm goes off: ☐ Yes ☐ No

- Confirm CGM results with a blood glucose meter check before taking action (hyperglycemia AND hypoglycemia)
- Insulin injections should be given at least three inches away from the CGM insertion site
- Do not disconnect from the CGM for sports/activities
- If the adhesive is peeling, reinforce with approved medical tape
- If the CGM becomes dislodged, return everything to the parent/guardian. DO NOT throw any part away

SUPPLIES TO BE FURNISHED BY PARENT/GUARDIAN: (Agreed upon locations noted on emergency card/action plan)

- ✓ Blood glucose meter, strips, lancets, lancing device
- ✓ Insulin pen/pen needles/cartridges
- ✓ Ketone testing strips
- ✓ Glucagon Emergency Kit
- ✓ Glucose Gel &/or Cake Gel Tube
- ✓ Other fast-acting carbohydrates (juice, glucose tabs)
- ✓ Other carbohydrate & protein snack: (i.e. peanut butter/cheese crackers, granola bars)

INSULIN ADMINISTRATION

INSULIN ADMINISTRATION DURING SCHOOL: ☐ Yes ☐ No **If yes, type of insulin**: ________________________
☐ School personnel not responsible for the administration of insulin

Student's self-care insulin administration skills:

☐ Independently calculates and gives own injections ☐ May calculate/give own injections with supervision
☐ Requires school nurse or UAP to calculate dose and student can give own injection with supervision
☐ Requires school nurse or UAP to calculate dose and give injection

Insulin Delivery: ☐ Pen ☐ Pump

Time to be given: ☐ Breakfast (☐Before ☐After); ☐ Lunch (☐Before ☐After); ☐ With Snack ☐AM ☐PM ☐ Other

****If "before" meal is selected and blood glucose is ≤ 100mg/dL or unsure if child will finish all of the meal, may give after meal****

Insulin Dosing: ☐ Carbohydrate ratio ☐ Sliding scale ☐ Standard daily insulin

CORRECTION FACTOR: 1unit of insulin for every ____ points that blood glucose is above or below target of ______mg/dL

Note: If pre-meal BG is less than target, the amount calculated for total insulin will be less than the amount calculated for food (carb) intake.

☐ Add correction dose to carbohydrate dose at meals

Correction Example

$$\frac{Current\ BG - Target\ BG}{Correction\ Factor} = ___Units\ of\ Insulin$$

CARBOHYDRATE (carbs) RATIO:

☐ Breakfast: 1 unit of insulin per _____ grams of carbs consumed
☐ AM Snack: 1 unit of insulin per _____ grams of carbs consumed
☐ Lunch: 1 unit of insulin per _____ grams of carbs consumed
☐ PM Snack: 1 unit of insulin per _____ grams of carbs consumed

Carbohydrate Example

$$\frac{Grams\ of\ Carb\ to\ be\ eaten}{Insulin\ to\ Carb\ Ratio} = ___Units\ of\ Insulin$$

SLIDING SCALE:

Blood sugar: _____- _____ Insulin Dose: ____
Blood sugar: _____- _____ Insulin Dose: ____
Blood sugar: _____- _____ Insulin Dose: ____
Blood sugar: _____- _____ Insulin Dose: ____
Blood sugar: _____- _____ Insulin Dose: ____

☐ **FIXED INSULIN DOSE at school (i.e. student is on predetermined number of units at prescribed time[s]):**

Type of insulin:	**Dose:**	**Time to be given**:
____________________	__________	_____________
____________________	__________	_____________
____________________	__________	_____________
____________________	__________	_____________
____________________	__________	_____________

PARENTS/GUARDIANS AUTHORIZATION TO ADJUST INSULIN DOSE

******Must be signed/initialed by healthcare provider AND Parents wishing to make changes are to contact the School's Registered Nurse******

MD initial

________ ☐ Yes ☐ No Parents/guardians authorization should be obtained before administering a correction dose

________ ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease correction factor within the following range: **+/-** ______ points that the blood glucose is above/below target blood glucose

________ ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease carb ratio within the following range: 1 unit per prescribed grams of carb. +/- ______ grams of carb.

________ ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: **+/-** ______ units of insulin

PHYSICAL ACTIVITY, SPORTS, and EMERGENT SITUATIONS (i.e. lockdown, fire, etc)

Quick access to water, fast-acting carbohydrate (glucose tabs, gummies, gel), and monitoring equipment is recommended to be available at all times.

MANAGEMENT OF HYPERGLYCEMIA (HIGH) BLOOD GLUCOSE (over 350 mg/dl)

Typical Signs/Symptoms of Hyperglycemia:

- Increased thirst, urination, appetite
- Tiredness/sleepiness
- Blurred vision
- Warm, dry, or flushed skin
- Other: ______________________________

Emergency Hyperglycemia Signs/Symptoms:

- Nausea and/or vomiting
- Rapid, shallow breathing
- Fruity breath
- Severe abdominal pain
- Increased sleepiness/lethargy
- Depressed level of consciousness

Provide the following treatment:

- Give extra water and/or sugar-free fluids as tolerated
- Use Insulin correction formula when blood sugar is over **350 and it has been 2 hours since last insulin, *CALL SCHOOL RN FIRST***
- Frequent bathroom privileges
- Check urine ketones if blood glucose over **350** mg/dl
- Return to clinic in 1 hour to recheck blood glucose if ketones trace or lower.
- CALL parents if ketones are more than trace.

If ketones are trace or lower it is not necessary for student to go home or to be kept in the clinic.

When ketones of small or greater are present:

- Stay with student and document changes in status.
- Call parent. If unable to reach parent, call School RN for appropriate instruction and/or contact of diabetes care provider.
- Student should be sent home.

MANAGEMENT OF HYPOGLYCEMIA (LOW) BLOOD GLUCOSE (below 70 mg/dl)

Hypoglycemia Symptoms		
Mild to Moderate		Severe
• Shaky or Jittery • Clammy/Sweaty • Hungry • Pale • Headache • Blurry vision	• Weak/Tired/Lethargic • Inattention/Confused/Disoriented • Dizziness/Staggering • Argumentative/Combative • Change in personality or behavior	• Slurred speech • Inability to eat or drink • Unconscious • Unresponsive • Seizure activity or convulsions (jerking movements)

- Usual symptoms for this student: ______________________________

Treatment for Mild to Moderate Hypoglycemia	Treatment for Severe Hypoglycemia
• Test Blood Glucose (BG) • Give 15 grams fast-acting carbohydrate such as: - 3-4 glucose tablets ***(preferred)*** - 4oz. Fruit juice or **non**-diet soda - Concentrated glucose gel or tube gel (for child with trouble swallowing) - 8oz. Milk - Other: ____________________ • Retest BG 15 minutes after treatment • Repeat treatment until blood glucose over 90 mg/dl • **Follow treatment with snack of 15 gr with protein** (i.e. cheese OR peanut butter crackers) ***if it will be more than 1 hour until next meal/snack or if going to activity*** • Other: ______________________________	**IMPORTANT!!!!** Administer glucose gel if student is awake but unable to drink or eat. **If student is unconscious or having a seizure, presume the student has low blood glucose and:** • **Trained personnel administer Glucagon** **< 9 years old ½ mg** **≥ 9 years old 1mg** • **While treating, have another person call 911.** • **Position student on his or her side, and maintain this position until recovered from episode.** • **Contact student's parent/guardian.** • **Stay with student until Emergency Medical Services arrive.** • **Notify EMS if student on insulin pump**

SIGNATURES

I/we understand that all treatments and procedures may be performed by the student and/or trained unlicensed assistive personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed this information sheet and agree with the indicated instructions. This form will assist the school health personnel in developing a nursing care plan.

Parent's Signature **(Required)**:____Date: ____________

Physician's Signature (**Required**): ____Date: ____________

School Nurse's Signature (**Required**): ______________________________________Date: ____________

For School Personnel Completion:

The following personnel are trained to provide care: ____

____

THIS

AREA

LEFT

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ADDENDUM - FOR STUDENTS WITH INSULIN PUMP
LEON COUNTY SCHOOLS
DIABETES MEDICAL MANAGEMENT & NURSING PLAN
(School Year ____________-_____________)

Effective Date(s) of Pump Plan: ________________________________

Brand/Model of pump: ________________________________

☐ For blood glucose greater than 300mg/dL that has not decreased within 2 hours **after correction**, consider pump failure or infusion site failure. Notify parent(s)/guardian(s) and refer to the ***Student's Self-Care Pump Skills*** below. ***Parent action is required if student is not independent. If unable to reach parent/guardian, contact school RN.***

Physical Activity
May disconnect from pump for sports activities: ☐ YES , for up to _____ minutes ☐ NO
Set a temporary basal rate: ☐ YES , ____% temporary basal for _____ minutes ☐ NO
Suspend pump use: ☐ YES , for up to _____ minutes ☐ NO

Student's Self-Care Pump Skills	Independent	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alerts and alarms	☐ Yes	☐ No
Give injection with pen/syringe if needed **and** pen/syringe available	☐ Yes	☐ No

Supplies to be furnished by parent(s)/guardian(s) based upon the *Student's Self-Care Pump Skills*:

☐ Infusion set/reservoir ☐ Batteries ☐ Rapid acting insulin pen or syringe to administer injection

SIGNATURES

Parent's Signature (Required):____**Date:** ___________

Diabetes Care Provider Signature (Required): ______________________________________**Date:** ___________

School Nurse's Signature (Required): _____________________________________**Date:** ___________