School_____ Year 20___ / 20___

Diabetes Health Care Plan for Southgate Schools

Diabetes Medical Management Plan, Initialized Healthcare Plan and Physician Orders

Part A: Contact Information must be completed by the parent/guardian.

Part B: Diabetes Medical Management Plan (DMMP) must be completed by the student's physician or advanced practice nurse and provides the medical "orders" for the student's care. This section must be signed and dated by the medical practitioner.

Part C: Student Agreement for students from 6th grade to exiting Southgate Schools.

Part D: Signature Page.

****Please note that we do not give an extra bolus for high blood sugar***

PART A: Contact Information School Year 20___/20___

Student's Name:_____Gender:____

Date of Birth:_____ Date of Diabetes Diagnosis_____

Grade and School:_____ Homeroom Teacher:_____

Mother/Guardian:_____

Address: _____

Telephone: Home:_____Work:_____Cell:_____

Email Address:_____

Father/Guardian:_____

Address_____

Telephone: Home_____Work:_____Cell:_____

Email Address: _____

Student's Physician/Healthcare Provider

Name:_____

Address:_____

Telephone:_____Emergency Number:_____

*** Other Emergency Contacts:**

Name:_____

Relationship:_____

Telephone: Home_____Work:_____Cell:_____

Please make sure your emergency contact is knowledgeable about your child's diabetes

PART B: Diabetes Medical Management Plan. This section must be completed by the student's physician or advanced practice nurse and provides the medical "orders" for the student's care. This section must be signed and dated by the medical practitioner. The information in the DMMP is used to develop the IHP and the IEHP.

Student's Name: _____

Effective Dates of Plan: _____

Physical Condition: ___Diabetes type 1 ___Diabetes type 2

1. Blood Glucose Monitoring

Target range for blood glucose is: 70-150 70-180 Other:_____

Usual times to check blood glucose_____

Times to do extra blood glucose checks (*check all that apply*)

☐ Beginning of school
☐ End of the School day
☐ After exercise
☐ Before exercise
☐ When students exhibits symptoms of hyperglycemia (high blood sugar)
☐ When students exhibits symptoms of hypoglycemia (low blood sugar)

Other (explain):_____

Can student perform own blood glucose checks? Yes No

Exceptions: _____

_____

Type of blood glucose meter used by student: _____

2. Type of Insulin Used

What type of insulin is the student currently using through out the school day? _____.

3. Insulin Correction Doses For Students Using a Pen

Authorization from the student's physician or advanced practice nurse must be obtained before administering a correction dose for high blood glucose levels as noted below. Changes must be faxed to the school nurse at 734-284-4476.

Should glucose levels be checked? Yes No

Can the student do this independently? Yes No

If no, does the student need supervision or someone to perform these duties? Yes No

0 units for blood glucose up to_____mg/dl

_____units if blood glucose is _____to_____mg/dl

_____units if blood glucose is _____to_____mg/dl

_____units if blood glucose is _____to_____mg/dl

_____units if blood glucose is _____to_____mg/dl

_____units if blood glucose is _____to_____mg/dl

Can student give own injections? Yes No

If yes, can the student do this independently? Yes No

If no, does the student need supervision or someone to perform these duties? Yes No

Can student determine correct amount of insulin? Yes No

If yes, can the student do this independently? Yes No

If no, does the student need supervision or someone to perform these duties? Yes No

Can student draw correct dose of insulin? Yes No

If yes, can the student do this independently? Yes No

If no, does the student need supervision or someone to perform these duties? Yes No

4. Students with Insulin Pumps

Type of pump:_____Basal rates:_____

Type of infusion set: _____

Insulin/Carbohydrate ratio:_____Correction Factor:_____

Student Pump Abilities/Skills

Can student count carbohydrates independently? Yes No

If no, does the student need supervision or someone to perform these duties? Yes No

Bolus correct amount for carbohydrates consumed Yes No

If no, does the student need supervision or someone to perform these duties? Yes No

Calculate and administer corrective bolus Yes No

If no, does the student need supervision or someone to perform these duties? Yes No

Keep a log of their blood sugar, meals, symptoms and etc Yes No

If no, does the student need supervision or someone to perform these duties? Yes No

Can student change his/her own pump site at school? Yes No
****Staff can not change the site but we can supervise****

5. Student Taking Oral Diabetes Medications

Type of Medication:_____ Timing:_____

Other Diabetes Medication_____ Timing:_____

6. Meals and Snacks Eaten at School

Is the student independent in carbohydrate calculations and management? Yes No

If no, does the student need supervision or someone to perform these duties? Yes No

Meal/Snack Time Food content/Amount

Breakfast: _____

Mid-morning snack:_____

Lunch: _____

Mid- afternoon snack: _____

Snack before exercise? Yes No Snack after exercise? Yes No

Other times to give snacks and content/amount:_____
_____

Preferred snack foods:_____

Foods to avoid, if any:_____

Instructions for class parties and food-consuming events:_____
_____

7. Exercise and Sports

A fast-acting carbohydrate such as_____
Should be available at the site of exercise or sports.

Restrictions on physical activity:_____

Student should not exercise if blood glucose level is below_____mg/dl or above_____mg/dl or if moderate to large urine ketones are present.

8. Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia_____
_____

Treatment of hypoglycemia:_____
_____

Hypoglycemia: Glucagon Administration

Glucagon should be given if the student is unconscious, having a seizure (convulsions), or unable to swallow. If Glucagon is required and the school nurse is not physically available to administer Glucagon then the student's trained diabetic advocate will administer the medication.

Once administered, call 911 and notify the parents/guardian.

9. Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia:_____
_____

Treatment of hyperglycemia:_____
_____

Urine should be checked for ketones when blood glucose levels are above

_____mg/dl

Treatment for ketones: _____
_____

10. Diabetes Care Supplies

While in school or at school-sponsored activities, the student is required to carry the following diabetic supplies:

Blood glucose meter, blood glucose test strips, and batteries for the meter

Lancet device and lancets

Urine ketone strips

Insulin pump and supplies

Insulin pen, pen needles, insulin cartridges, syringes

Fast-acting source of glucose

Carbohydrate containing snack

Glucagon emergency kit

Bottled Water

. Other _____

****If these supplies are running low or if they are not present in the kit the parent will be contacted to bring in more supplies. ****

11. Exiting the School Building:

Please state the blood sugar parameters when the student is leaving the school building without a parent/guardian. (e.g. walking home for the day or field trips).

Student's blood sugar must be above_____ and below_____.

****If the student is exhibiting high blood sugar and has large ketones we will call home for the student to be picked up. ****

Part C: Student (6th – 12th grade) Agreement of Managing Their Diabetes.

I agree to dispose of any sharps by placing them in the sharps container provided at school.

I will notify my diabetic advocate if my blood sugar is below_____mg/dl or above_____mg/dl.

I will not allow any other person to use my diabetes supplies.

I plan to keep my diabetes supplies with me at all times.

I will be responsible for having all of my supplies in my kit.

Student Signature:_____ Date:_____

Part D: Signature Page

This Diabetes Medical Management Plan has been approved by:

_____ _____
Signature: Student's Physician/Healthcare Provider Date

Student's Physician/Healthcare Provider Contact Information:

Name:_____

Address:_____

Telephone:_____Emergency Number:_____

Additional Orders:_____
_____
_____

Parent Signature:_____Date:_____

This Diabetes Medical Management Plan has been reviewed by:
_____ _____
School Nurse Date