Lake Wales Charter Schools

Diabetes Medical Management Plan for School Year 20_____ - 20_____

1. DEMOGRAPHIC INFORMATION ---PARENT TO COMPLETE			
Student's Name: _____		DOB: _____	Diabetes Type: _____
Date Diagnosed: Select Month from Pulldown (or fill in here: __________)		Year: _____	
School: _____		Grade: _____	Home Room: _____
Parent/Guardian #1: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian #2: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian's E-mail Address: _____			
Diabetes Healthcare Provider: _____		Phone: _____	Fax: _____
Diabetes Educator/Insulin Pump Resource: _____		Phone: _____	Fax: _____

2. STUDENT SELF-MANAGEMENT SKILLS PARENT TO COMPLETE	Dependent-Care (Supervision Needed)	Transitional-Care (Progress to Independence)	Self-Care (No Supervision Needed)
Performs and Interprets Blood Glucose Tests	☐	☐	☐
Management of High/Low Blood Glucose	☐	☐	☐
Carries, Maintains, and Uses Diabetes Supplies as Needed	☐	☐	☐
Calculates Carbohydrate Grams	☐	☐	☐
Determines Insulin Dose for Carbohydrate Intake	☐	☐	☐
Determines Dose and Timing of Correction Insulin	☐	☐	☐

Dependent-Care: Student needs assistance or supervision by trained staff.

Transitional-Care: Student will receive assistance and be monitored until student demonstrates competency according to *Diabetes Skills Checklists for Students*. When the student progresses to performing care independently, they will provide a weekly log to the nurse.

Self-Care: Student is able to perform the diabetes care without help or supervision. Student may provide this self-care at any time and in any location at the school, on field trips, at sites of extracurricular activities, and on school bus.
Support is provided upon request and as needed.

***Parent is responsible** for providing diabetes supplies and food prescribed in the DMMP. If diabetes care is required during a school-sponsored activity after regular school hours, the parent is responsible for obtaining an updated DMMP for the activity**.**

3. TESTING BLOOD GLUCOSE AT SCHOOL---PARENT TO COMPLETE

School Start Time:_____ School End Time:_____ ☐ Walker/Bike Rider ☐ Car Rider ☐ Bus Rider ☐ Other: _____

Test Blood Glucose as needed for signs/symptoms of high/low blood glucose and:

☐ Before Breakfast: Breakfast Time:_____ ☐ Before Lunch: Lunch Time:_____ ☐ Before PE: PE Time:_____ ☐ Other : _____

Notify parent if blood glucose is below _____ mg/dl or above _____ mg/dl.

Continuous Blood Glucose Monitor (CGM): Treatment must be based on glucometer results NOT CGM.
Low alarm _____ mg/dL Repeat Low alarm _____ minutes High alarm _____mg/dL Repeat High alarm _____ minutes

☐ CGM is remotely monitored by parent. Parent will report hypoglycemia or hyperglycemia to clinic staff.

Does student recognize signs of **LOW** blood glucose? ☐ Yes ☐ No

Students Usual Signs and Symptoms: ☐ Weak/Shaky ☐ Irritable ☐ Confused ☐ Other: _____

Does student recognize signs of **HIGH** blood glucose? ☐ Yes ☐ No

Students Usual Signs and Symptoms: ☐ Increased Thirst and/or Urination ☐ Stomachache ☐ Nausea/ Vomiting ☐ Other: _____

Fax DMMP to Health Services @ 863-291-5723 Date and Initial: __________, __________, __________, __________, __________

STUDENT'S NAME: ____________________ **SCHOOL:** ____________________

4. LOW BLOOD GLUCOSE MANAGEMENT---HEALTHCARE PROVIDER TO COMPLETE

Management of Low Blood Glucose below _____ mg/dL (or below 70 mg/dL if not specified)

1. Check ketones if student complains of any illness, stomachache or nausea/vomiting. If positive, see "Management of Ketones" Section 6 below.
2. If student is awake and able to swallow: give _____ grams of fast-acting carbohydrates (or 15 grams if not specified, such as 4 oz. fruit juice, 3-4 glucose tablets, regular soda, milk, or 15 gm tube of glucose gel)
3. Recheck blood glucose every 15 minutes and re-treat until blood glucose if over _____ mg/dL (or 80 mg/dL if not specified).
4. Delay exercise if blood glucose is below _____ mg/dL (or 100 mg/dL if not specified).
5. Notify parent. See "Testing Blood Glucose at School" Section 3 above.

If student is unconscious or having a seizure, treat first as indicated below, call 911 immediately and notify parents. Position student on side if possible.

If wearing an insulin pump, place pump in suspend/stop mode or disconnect/cut tubing. Send pump with EMS.

Glucagon: ☐ 0.5 mg ☐ 1.0 mg Administered SubQ or IM injection by trained personnel. Glucagon is stored in_____.

Fax Diabetes Documentation Log to Health Care Provider: If blood glucose is below _____ mg/dL _____ times in _____ week(s) (or below 70 mg/dL more than two times in one week if not specified).

5. HIGH BLOOD GLUCOSE MANAGEMENT---HEALTHCARE PROVIDER TO COMPLETE

Management of High Blood Glucose over _____ mg/dL (or over 250 mg/dL if not specified)

1. Refer to the "Insulin Administration" Section 7 below for designated times correction insulin may be given.
2. Give water or other calorie-free liquids as tolerated and allow frequent bathroom privileges.
3. Check ketones if blood glucose over _____ mg/dL (or over 300 mg/dL [240 mg/dL for pumps] if not specified) **OR** for complaint of any illness, stomachache or nausea/vomiting regardless of blood glucose levels. If positive, see "Management of Ketones" Section 6 below.
4. Notify parent/guardian if blood glucose over _____ mg/dL (or over 250 mg/dL if not specified) and/or positive ketones.
5. Recheck blood glucose over _____ mg/dL in _____hours (or over 250 mg/dL in 2 hours if not specified).

*****Pump users: Check if pump is on, time of last bolus for history of missed bolus, cartridge empty, tubing kinked, tubing or site leakage, loose site, or site redness.**

Fax Diabetes Documentation Log to Health Care Provider: If pre-meal blood glucose is above _____ mg/dL more than _____ times per week (or above 250 mg/dl more than two times per week if not specified).

6A. MANAGEMENT OF TRACE/SMALL KETONES---HEALTHCARE PROVIDER TO COMPLETE

Trace/Small Urine Ketones (or blood 0.6 – 1 mmol/L):

1. Notify parent/guardian.
2. Give water every 30-60 minutes: Age 9 and under drink 4-6 oz. Age 10 and above drink 8 oz.
3. May return to class if feeling well.
4. Recheck blood glucose and ketones in 2 hours.

Management of Moderate to Large Urine Ketones (or blood over 1 mmol/L) See Section 6B below:

STUDENT'S NAME: ______________________________ **SCHOOL:** ______________________________

6B. MANAGEMENT OF MODERATE TO LARGE KETONES---HEALTHCARE PROVIDER TO COMPLETE

Moderate to Large Urine Ketones (or blood over 1 mmol/L): This level of ketones is serious and requires additional insulin and extra sugar-free fluids to avoid **Diabetic Ketoacidosis (DKA)**. For insulin pump users, it often indicates that the pump is not administering insulin and insulin must be given via injection. Insulin orders outside of those indicated in this plan require Medical orders in writing.

1. Notify parent/guardian immediately and call diabetes healthcare provider for instructions. **Medical orders must be in writing; NO verbal orders accepted.**
2. Give water every 30-60 minutes: Age 9 and under drink 4-6 oz. Age 10 and above drink 8 oz.
3. Student cannot exercise/participate in physical activity.
4. If unable to reach parent or diabetes healthcare provider, and student is vomiting or unable to drink water, having labored breathing, or unconscious call 911.
5. Recheck blood glucose and ketones in _____ hours (or in 1 hours if not specified). Recheck urine ketones with every void.
6. **Insulin Pumps Users: Contact parent for pump site, insulin, and cartridge change as soon as possible.**

7. INSULIN ADMINISTRATION---HEALTHCARE PROVIDER TO COMPLETE

Insulin **correction** for ***high blood glucose*** at school, indicate times: ☐ Before Breakfast ☐ Before Lunch

Insulin at school: ☐ Humalog ☐ Novolog ☐ Apidra ☐ Other:_____

Insulin delivery via: ☐ Pen ☐ Syringe ☐ Pump ☐ Dosing to be determined by insulin pump or smart meter.

8. HIGH BLOOD SUGAR CORRECTION DOSE--Sliding Scale-HEALTHCARE PROVIDER TO COMPLETE

Blood sugar _____ to _____	Insulin Dose = _____ units	Blood sugar _____ to _____	Insulin Dose = _____ units
Blood sugar _____ to _____	Insulin Dose = _____ units	Blood sugar _____ to _____	Insulin Dose = _____ units
Blood sugar _____ to _____	Insulin Dose = _____ units	Blood sugar _____ to _____	Insulin Dose = _____ units

9. HIGH BLOOD SUGAR CORRECTION DOSE--Correction (Sensitivity) Factor-HEALTH PROVIDER TO COMPLETE

Blood Glucose_______(Minus) ***Target*** (=) ______ (Divide) ***Correction Factor*** (=) _______Units for High B/G

10. CARBOHYDRATE INSULIN DOSE---HEALTHCARE PROVIDER TO COMPLETE

Insulin for ***carbohydrates*** eaten at school, indicate times: ☐ Before Breakfast ☐ Before Lunch ☐ Snacks/Other:_____

Give one unit of insulin per __ grams of carbohydrates. ☐ Dosing to be determined by insulin pump or smart meter.

If parent provides food, carb count must be provided for each item.

I hereby authorize the above named physician and Lake Wales Charter Schools, Inc./Florida Department of Health in Polk County staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Lake Wales Charter Schools, Inc. protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I request that my child be assisted in taking the medication or treatment described above at school by authorized persons as permitted by my physician and me.

Student Signature (if providing self-care/carrying supplies on person): ____________________

Parent/Guardian Signature: ____________________ **Date:** __________

Physician's/Mid-Level Practitioner's Signature: ____________________ **Date:** __________

School Health Registered Nurse Signature: ____________________ **Date:** __________

Place Office Stamp Here

STUDENT'S NAME: ____________________ **SCHOOL:** ____________________