CITY SCHOOL DISTRICT OF NEW ROCHELLE

HEALTH SERVICES DEPARTMENT

DIABETES MELLITUS MEDICAL MANAGEMENT PLAN

School Year: **20_____ to _____** **School: _____** **Grade: _____**

Student's Name: _____ Date of Birth:_____ Hgb A1C _____ → Date ___/___/___

BLOOD GLUCOSE (BG) MONITORING: Target Blood Glucose range: _____mg/dl to _____mg/dl

□ **Before meals** □ **As needed for suspected low/high BG**

□ **2 hours after correction** □ **Midmorning** □ **Midafternoon**

□ **Continuous BG monitor: □ No □ Yes Brand/Model: _____ □ Instructions: _____**

INSULIN ADMINISTRATION: Insulin delivery system: □Syringe □ Pen □ Pump

INSULIN TYPE: □ Humalog □ Novolog □ Apidra □ Other

MEAL INSULIN: (It is best if given right **before eating.** For small children, can give within 15-30 minutes of the first bite of food or right after meal)

□ Insulin to Carbohydrate Ratio: ____unit per _____ grams carbohydrate

□ Set Doses: Give _____ units (Eat _____ grams of carbohydrates)

Hyperglycemia Correction Insulin: Add before meal insulin to correction/sliding scale insulin for total meal time insulin dose.)

□ Use the following correction formula
(for pre-lunch blood sugar over _____)
(**BG**- ____) ÷ _____ = units insulin to provide

□ Sliding Scale: □ For disaster only
BG from _____ to _____ =_____ u
BG from _____ to _____ =_____ u
BG from _____ to _____ =_____ u
BG from _____ to _____ =_____ u

Carbohydrate Coverage Example:
Gm CHO = Units of Insulin
Insulin: Carb Ratio

Total Dose = Meal Insulin + Hyperglycemic Correction Insulin

Management of low and high blood sugar

MILD low sugar: Alert and cooperative student (BG below 70)
□ Never leave student alone
□ Give 15 grams glucose, as _____, check in 15 minutes
If BG remains below 70, retreat and recheck in 15 minutes
□ Notify parent if not resolved
□ If meal time, allow student to eat meal, under supervision.
□ If no meal is scheduled in the next hour, provide an additional snack with carbohydrate, fat, protein.
□ Other: _____

SEVERE low sugar: Loss of consciousness or seizure
□ **Call 911.** Open airway. Turn to side
Glucagon injection □**0.25 mg** □**0.50 mg** □**1.0 mg IM/SQ**
□ Notify parent
□ For students using insulin pump, stop pump by placing in "suspend or stop Mode, disconnecting at pigtail or clip, and/or removing an attached pump. If Pump was removed, send with EMS to hospital.

Management of high blood glucose (above 200 mg/dl)

□ Sugar-free fluids/frequent bathroom privileges
□ If BG is greater than 300, and it's been 2 hours since last dose given, give □**HALF** □**FULL** correction formula noted above
□ If BG is greater than 300 check for ketones. Notify parent if ketones are present.
□ Note and document changes in status.

MANAGEMENT DURING PHYSICAL ACTIVITY:

Student shall have easy access to fast-acting carbohydrates, snacks, and blood glucose monitoring equipment during activities.

□ Child should NOT exercise if blood glucose levels are below _____ mg/dl or above _____ mg/dl and urine contains moderate or large ketones.

□ Check blood sugar right before physical education to determine need for additional snack.

□ If BG is less than 70 mg/dl , eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.

□ Student may disconnect insulin pump for 1 hour or decrease basal rate by _____.

□ At the beginning of a new activity check blood sugar before and after exercise only until a pattern for management is established.

□ A snack is required prior to participation in physical education.

MEAL PLAN:

□ A snack will be provided each day at: _____

□ If regularly scheduled meal plan is disrupted, provide additional snack

SPECIAL MANAGEMENT OF INSULIN PUMP:

□ Contact Parent in event of: ●pump alarms or malfunctions ●detachment of dressing / infusion set out pf place ●Leakage of insulin ●Student must give insulin injection ●Student has to change site ●Soreness or redness at site ●Corrective measures do not return blood glucose to target range within _____ hours

INSULIN THERAPY FOR DISASTER: Check Blood Glucose every 4 hours and/or if student has symptoms consistent with high or low blood sugar. □ **Use Sliding Scale** **OR** □ **Give insulin following these instructions: _____**

STUDENT NAME: _____ **DATE OF BIRTH:** _____

This student requires assistance by the School Nurse with the following aspects of diabetes management:

□ Monitor and record blood glucose levels
□ Respond to elevated or low blood glucose levels
□ Administer glucagon when required
□ Administer insulin or oral medication
□ Follow instructions regarding meals and snacks
□Follow instructions as related to physical activity
□ Insulin pump management: administer insulin, inspect infusion site, contact parent for problems
□ Student may use electronic device to manage diabetes
□ Provide other specified assistance: _____

_____

_____

This student may independently perform the following aspects of diabetes management, in which my Practice has instructed the student:

Monitor blood glucose:
- □ in the classroom
- □ in the designated clinic office
- □ in any area of the school and at any school related activity

□ Monitor urine or blood ketones
□ Administer insulin
□ Treat hypoglycemia (low blood sugar)
□ Treat hyperglycemia (elevated blood sugar)
□ Carry supplies for blood glucose monitoring
□ Carry supplies for insulin administration
□ Determine own snack/meal content
□ Manage insulin pump
□ Replace insulin pump infusion set

EMERGENCY NOTIFICATION: Notify parents of the following conditions:

□ Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon.
□ Blood sugars in excess of 300 mg/dl, when ketones present.
□ Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.
□ Blood sugar below 70 that does not respond to treatment
□ Other: _____

Parent/Guardian: _____ HM Phone: _____ Work: _____ Cell/Pager: _____

Parent/Guardian: _____ HM Phone: _____ Work: _____ Cell/Pager: _____

Other emergency contact: _____ Phone #: _____ Relationship: _____

SIGNATURES: I understand that treatments and procedures may be performed in various locations within the school.. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's Diabetes provider for guidance and recommendations. If, in the clinical judgement of the School Nurse and/or Medical Director, the student cannot be safely treated in the school setting, the student will be medically dismissed to the care of the parent and/or the treating health practitioner. I understand that students dismissed for Diabetes medical care at home may return to school the next school day at the earliest. I have reviewed this form and verify the accuracy of the information. I agree to provide supplies, equipment, and medication for my child's Diabetes. I will sign and submit trip permission forms a minimum of 1 week before the trip.

SUPPLIES TO BE FURNISHED/RESTOCKED BY PARENT/GUARDIAN: (Agreed –upon locations noted on emergency card/nursing care plan)

□Blood glucose meter/strips/lancets/lancing device	□Fast-acting carbohydrate_____	□Insulin vials/syringe
□Ketone testing strips	□Carbohydrate-containing snacks	□Insulin pen/pen needles/cartridges
□Plastic Container for Supplies	□Carbohydrate free beverage/snack	□Glucagon Emergency Kit

Parent Signature: _____ **DATE**_____

For NYC Residents:
I understand that I am required to provide, attached to this form, proof of residency which will satisfy NYC Board of Education requirements. This includes the residency form, and a copy of my most recent Con Edison utility bill.
Parent Signature: _____

My signature provides authorization for the above Diabetes Mellitus Medical Management Plan. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year. Student is due for medical appointment for review of diabetes management plan on _____.

HEALTHCARE PROVIDER SIGNATURE: _____ Date: _____

Physician Stamp:

Health Care Provider:_____

Address:_____

Phone: _____ Fax:_____

NYS License# _____ Email:_____