Parent Form (p.1 of 2)

DIABETES MEDICAL MANAGEMENT PLAN

This form must be renewed each school year or with any change in treatment plan

Student's Name: _____ **Date of Birth:** _____

PARENT CONSENT FOR DIABETES MEDICAL MANAGEMENT PLAN

We (I), the undersigned, the parent(s)/guardian(s) of the above named child, request that this Diabetes Medical Management Plan, and any modification thereto, be implemented while our (my) child is at school or attending a school-related event on or off campus. We (I) understand that the services will be administered to our (my) child in accordance with Education Code section 49423.5. We (I) understand that specialized physical health care services may be performed/monitored by unlicensed designated school personnel under the training and supervision provided by a credentialed school nurse. We (I) agree to:

- Provide the necessary supplies, snacks, medications, and equipment.
- Notify the school nurse if there is a change in pupil health status or attending physician.
- Notify the school nurse immediately and provide new written consent for any changes to this order form.

We (I) understand that we (I) will be provided with a copy of our (my) child's completed Diabetes Medical Management Plan.

We (I) authorize the school nurse to communicate with the physician when necessary.

We (I) also consent to the release of information contained in the Diabetes Medical Management Plan to the **CHINO VALLEY UNIFIED** School District staff and other adults who have custodial care of our (my) child and who may need to know this information to maintain our (my) child's health and safety. This consent also extends to other adults who may need to know the information contained in this Diabetes Medical Management Plan to maintain our (my) child's health and safety.

We (I) understand that any written parent/guardian consent for modifications that require physician authorization, as noted above, will not be implemented unless written physician authorization is also submitted to school personnel. All modifications to the Diabetes Medical Management Plan MUST be in written form. The requests for modification received in writing must include the date, the modification, and signatures of both the parent/guardian and the school employee receiving the modification, and a written physician authorization if required. These changes will be attached to his/her Diabetes Medical Management Plan and will be maintained in the student's health record.

Student's Parent/Guardian (please print)	Student's Parent/Guardian (signature)	Date
Student's Parent/Guardian (please print)	Student's Parent/Guardian (signature)	Date

Reviewed by School Nurse _____ (signature) _____ Date

Reviewed by Principal _____ (signature) _____ Date

DIABETES MEDICAL MANAGEMENT PLAN

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Contact Information

Student's Name: _____ **Date of Birth:** _____

School Name: _____ Grade: _____ Teacher: _____

Mother/Guardian: _____	**Father/Guardian:** _____
Telephone: Home ( ) _____	Telephone: Home ( ) _____
Work ( ) _____	Work ( ) _____
Cell ( ) _____	Cell ( ) _____
Address: _____	Address: _____
_____	_____

Student's Primary Care Provider

Name: _____

Address: _____
Street City Zip

Telephone: ( ) _____ Emergency Number: ( ) _____

Student's Pediatric Endocrinologist (3 to 4 visits are recommended each year)

Name: _____

Address: _____
Street City Zip

Telephone: ( ) _____ Emergency Number: ( ) _____

Additional Emergency Contact:

Name: _____ Relationship: _____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Physician Form (p.1 of 3)

DIABETES MEDICAL MANAGEMENT PLAN

This form must be renewed each school year or with any change in treatment plan

Student's Name: _____ **Date of Birth:** _____

Physical Condition: ☐ **Type 1 Diabetes** ☐ **Type 2 Diabetes** **Date of Diagnosis:** _____

The Effective Date of this Plan is from: _____ until the end of the school year.

Medications Taken at Home

Insulin Medication				***Oral Medication***		
Pre-Breakfast:						
	Medication	*Amount*	*Time*	*Medication*	*Amount*	*Time*
Pre-Bedtime						
	Medication	*Amount*	*Time*	*Medication*	*Amount*	*Time*
Other						
	Medication	*Amount*	*Time*	*Medication*	*Amount*	*Time*

Snacks Ordered for School

Snack	***Time***	***Food Content/Amount***
Mid-Morning Snack		
Mid-Afternoon Snack		
Other times to give snacks		

Snack before exercise ☐ Yes ☐ No Snack after exercise ☐ Yes ☐ No

Preferred snack foods: _____

Foods to avoid, if any: _____

Instructions when food is provided to the class (e.g., class parties): _____

_____

Exercise and Sports

Liquid and solid carbohydrate sources must be available before, during and after all exercise.

Exercise (Check and/or complete all that apply):

☐ No exercise if most recent blood glucose is less than 70 or _____

☐ Eat _____ grams of carbohydrates before vigorous exercise

☐ No exercise when blood glucose is greater than _____ or ketones are present

☐ ***Following treatment for hypoglycemia, no P.E. participation until blood sugar is at least above 80 and a carbohydrate and protein snack has been given.***

Field Trips:

Juice, snacks, and/or Glucagon **MUST** be available to student on all field trips or bus trips in case student requires treatment of hypoglycemia. The driver/chaperone should know of any student with diabetes in their care, in the event of an emergency.

Physician's Signature: _____ Date: _____

Physician Form (p.2 of 3)

DIABETES MEDICAL MANAGEMENT PLAN

This form must be renewed each school year or with any change in treatment plan

Student's Name: _____ **Date of Birth:** _____

Blood Glucose Monitoring

Target blood glucose range _____ to _____

Routine times to check blood glucose at school are:

☐ before lunch ☐ before exercise ☐ after exercise
☐ when student exhibits symptoms of hyperglycemia or hypoglycemia
☐ other: _____

Student can perform own blood glucose checks ☐ **School personnel must perform blood checks**
☐ with supervision ☐ without supervision ☐ **Exceptions:** _____

Insulin Administration at School

Insulin administration at school by student as follows: (*a. & b. not recommended independently below age twelve years)*

a. Determine insulin dose	☐ Self perform-adult observe	☐ Nurse or parent-supervised	☐ Dependent admin.
b. Measure insulin	☐ Self perform-adult observe	☐ Nurse or parent-supervised	☐ Dependent admin.
c. Inject insulin (vial/pen)	☐ Self perform-adult observe	☐ Nurse or parent-supervised	☐ Dependent admin.
d. Insulin pump	☐ Self perform-adult observe	☐ Nurse or parent-supervised	☐ Dependent admin.

Independent Management:

☐ Independent in Insulin administration (insulin should be kept in the health office or in the student's insulin pump.)

Medication During School Hours

Food/bolus doses (Check all that apply):

☐ **Standard lunchtime dose:** _____

☐ **Lunch insulin to carbohydrate ratio:**

_____ units ☐ Humalog ☐ Novolog for **30** grams of carbohydrates
_____ units ☐ Humalog ☐ Novolog for **45** grams of carbohydrates
_____ units ☐ Humalog ☐ Novolog for **60** grams of carbohydrates
_____ units ☐ Humalog ☐ Novolog for _____ grams of carbohydrates

☐ **Correction Scale / Calculation:**

Written sliding scale as follows:

Blood Glucose from _____ to _____ = _____ units
Blood Glucose from _____ to _____ = _____ units
Blood Glucose from _____ to _____ = _____ units
Blood Glucose from _____ to _____ = _____ units
Blood Glucose from _____ to _____ = _____ units
Blood Glucose from _____ to _____ = _____ units

☐ **Snack Bolus:** _____ units ☐ Humalog or ☐ Novolog for every _____ grams of carbohydrates

☐ **Insulin Therapy for Disaster:** Check blood glucose every 4 hours and give insulin using ☐ above scale or ☐ give Insulin following these instructions: _____

☐ **Insulin at school for this student is for disaster only.**

(Insulin doses should be given at least 2 hours apart to prevent overlapping insulin and hypoglycemia.)

Physician's Signature: _____ Date: _____

DIABETES MEDICAL MANAGEMENT PLAN

This form must be renewed each school year or with any change in treatment plan

Student's Name: _____ **Date of Birth:** _____

A. Treatment of LOW blood sugar: ☐ less than 70 ☐ less than 80 ☐ Other _____

If hypoglycemic (low blood sugar) symptoms are present student must be supervised AT ALL TIMES!

Following treatment for hypoglycemia, no P.E. participation until the blood sugar is at least above the blood sugar indicated above and a carbohydrate and protein

Step 1: give student *one* of the following carbohydrate selections:

- 4 ounces (1/2 cup) any type of fruit juice
- 1 cup of milk
- 4 ounces (1/2 cup) regular soda – NOT DIET SODA!
- 2 - 3 glucose tablets
- 15 grams of Insta-Glucose™
- 1 small tube of Cake Mate™ gel

Step 2: Wait approximately

☐ 10 *OR* ☐ 15 minutes to allow blood glucose (BG) to rise – Do not give food yet.
☐ 10 *OR* ☐ 15 minutes to allow BG to rise, if lunchtime, may eat while waiting (should be supervised)

Step 3: Recheck blood sugar:

If BG (blood glucose) level is below the low blood sugar value checked above:
Repeat Steps 1 and 2 again. If blood sugar does not rise above hypoglycemia level after 3 attempts then notify parents and the school nurse.

If BG level is equal to or above the low blood sugar value checked above:
Send the student to lunch, but if the lunch or snack is more than one hour away, 10 to 15 minutes after the Step 1 carbohydrate selection above:

☐ Follow with carbohydrate-and-protein-combination snack *(e.g., cheese and crackers, peanut butter and crackers, ½ of a meat or cheese sandwich)*
☐ If **Carb-counting**, follow with a protein snack
☐ If **Carb-counting**, *and going to PE before lunch*, may have a carbohydrate and protein snack

The student may return to scheduled class assignment, but may have difficulty concentrating for up to 1 hour following the hypoglycemic event.

Glucagon (intramuscular injection): Glucagon dosage: ☐ 1 mg

If student loses consciousness or is having a seizure DO NOT put anything in the child's mouth

Step 1: Administer **Glucagon** intramuscularly by school nurse, or trained personnel **immediately**
Step 2: Call **911** immediately
Step 3: **Turn** student to side (left side if possible) to avoid risk of aspiration
Step 4: Notify the student's parent/guardian as soon as possible

B. Treatment of HIGH blood sugar (greater than 250 mg/dL):

☐ Student should drink 8 oz of water or DIET soda every hour and carry water bottle as needed
☐ Student should be excused to use restroom as often as needed
☐ Check urine ketones if blood sugar is greater than _____ Mg/dL. If **moderate** to **large ketones,** DO NOT allow student to exercise and contact parent or health care provider
☐ If student has nausea, vomiting, stomach ache, or is lethargic, call school nurse and parents **as soon as possible.** ***Monitor student and if needed call 911.***
☐ Send student back to class if none of above physical symptoms are present.

Physician's Signature: _____ Date: _____
Physician's Name: _____ Telephone: ( ) _____
Physician's Address: _____ Fax: ( ) _____
Advanced Practice Nurse Name: _____ Telephone: ( ) _____