



*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



## Contact Information

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

<b>Mother/Guardian:</b> _____  Telephone: Home    (     ) _____  Work    (     ) _____  Cell     (     ) _____  Address:                _____  _____	<b>Father/Guardian:</b> _____  Telephone:    Home    (     ) _____  Work    (     ) _____  Cell     (     ) _____  Address:                _____  _____
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### 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: (        )

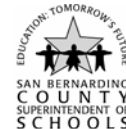
**Additional Emergency Contact:**

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***

<b><i>Insulin Medication</i></b>	<b><i>Oral Medication</i></b>
<b><i>Pre-Breakfast:</i></b> <div style="text-align: center; margin-top: 10px;"><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div></div> <div style="text-align: center; margin-top: 5px;"><i>Medication      Amount      Time</i></div>	<div style="text-align: center; margin-top: 10px;"><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div></div> <div style="text-align: center; margin-top: 5px;"><i>Medication      Amount      Time</i></div>
<b><i>Pre-Bedtime</i></b> <div style="text-align: center; margin-top: 10px;"><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div></div> <div style="text-align: center; margin-top: 5px;"><i>Medication      Amount      Time</i></div>	<div style="text-align: center; margin-top: 10px;"><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div></div> <div style="text-align: center; margin-top: 5px;"><i>Medication      Amount      Time</i></div>
<b><i>Other</i></b> <div style="text-align: center; margin-top: 10px;"><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div></div> <div style="text-align: center; margin-top: 5px;"><i>Medication      Amount      Time</i></div>	<div style="text-align: center; margin-top: 10px;"><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div><div style="display: inline-block; width: 30%; border-bottom: 1px solid black; margin-bottom: 5px;"></div></div> <div style="text-align: center; margin-top: 5px;"><i>Medication      Amount      Time</i></div>

**Snacks Ordered for School**

<b><i>Snack</i></b>	<b><i>Time</i></b>	<b><i>Food Content/Amount</i></b>
Mid-Morning Snack	_____	_____
Mid-Afternoon Snack	_____	_____
Other times to give snacks	_____	_____
Snack before exercise <input type="checkbox"/> Yes <input type="checkbox"/> No		Snack after exercise <input type="checkbox"/> Yes <input type="checkbox"/> 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.

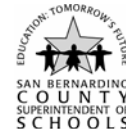
**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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    | <input type="checkbox"/> Self perform-adult observe | <input type="checkbox"/> Nurse or parent-supervised | <input type="checkbox"/> Dependent admin. |
| b. Measure insulin           | <input type="checkbox"/> Self perform-adult observe | <input type="checkbox"/> Nurse or parent-supervised | <input type="checkbox"/> Dependent admin. |
| c. Inject insulin (vial/pen) | <input type="checkbox"/> Self perform-adult observe | <input type="checkbox"/> Nurse or parent-supervised | <input type="checkbox"/> Dependent admin. |
| d. Insulin pump              | <input type="checkbox"/> Self perform-adult observe | <input type="checkbox"/> Nurse or parent-supervised | <input type="checkbox"/> 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	<input type="checkbox"/> Humalog	<input type="checkbox"/> Novolog for <b>30</b> grams of carbohydrates
_____ units	<input type="checkbox"/> Humalog	<input type="checkbox"/> Novolog for <b>45</b> grams of carbohydrates
_____ units	<input type="checkbox"/> Humalog	<input type="checkbox"/> Novolog for <b>60</b> grams of carbohydrates
_____ units	<input type="checkbox"/> Humalog	<input type="checkbox"/> 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: \_\_\_\_\_

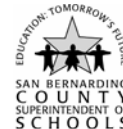
☐ Insulin at school for this student is for disaster only.

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

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



*Physician Form (p.3 of 3)*  
**DIABETES MEDICAL MANAGEMENT PLAN**  
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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, 1/2 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: (     ) \_\_\_\_\_