FHUSD DIABETIC MEDICAL MANAGEMENT PLAN

McDowell Mtn. 480-664-5201 | Middle School 480-664-5402 | High School 480-664-5501

Parent/Guardian must complete pages 1 and 2 only. The Physician or licensed Healthcare Provider must complete the remainder of the Fountain Hills Unified School District Diabetic Management Plan.

Diabetic Care Plan for: ____
(Student's Name)

Effective Date: ____/____/______ Grade: ____ Homeroom Teacher: _________________________
(See attached Classroom Schedule for Fountain Hills Middle and High School)

Birth Date: ____/____/_____

Date of diagnosis: ____/____/______ Diabetes Type 1☐
Diabetes Type 2☐

Emergency Contact Information

Parent/Guardian #1. ____ Home Phone: _____-_____-_______

Work Phone: _____-_____-_______ Ext# _________ Cell Phone: _____-_____-_______

Address: ____

Parent/Guardian #2. ____ Home Phone: _____-_____-_______

Work Phone: _____-_____-_______ Ext# _________ Cell Phone: _____-_____-_______

Address: ____

Student's Physician/Healthcare Provider: ____

Address: ____

Telephone: _____-_____-_______ Emergency telephone or pager: _____-_____-_______

Other Emergency Contact: ____ Home Phone: _____/_____/_______

Cell Phone: _____/_____/_______ Work Phone: _____/_____/_______ Relationship to student: ___________________

Address: ____

Notify parent/guardian or emergency contact in the following situations: _______________________________________

____

Parent/Guardian please read and sign the Consent for Care on the next page of this form.

Diabetic Care Plan for: ____

(Student's Name)

Parent/ Guardian Consent for Care
(To be completed by Parent/Guardian)

I/we give permission to the FHUSD Registered Nurse, Health Aide or designated staff members of

McDowell Mountain Elementary School Fountain Hills Middle School Fountain Hills High School

To perform and carry out the Diabetic Medical Management Plan as outlined by_________________________

(Physician/Licensed Healthcare Provider)

I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I understand it is the responsibility of the Parent/Guardian to inform both the physician or licensed healthcare provider and school of any changes in the student's health status. I/we give permission for release of information to/from the FHUSD to/from the physician/ licensed healthcare provider for the school year 20___-20___.

I have read and received a copy of the FHUSD Diabetes Medical Management Plan.

____ ____

Parent/Guardian #1 Date Parent/Guardian #2 Date

Supplies to be kept at School (All supplies listed below are to be provided by the parent/guardian.)

- Blood glucose meter, blood glucose test strips, batteries for meter, copy of the instruction manual and high/low calibration testing.
- Lancet device, lancets, gloves, etc.
- Urine ketone strips
- Insulin vials and syringes
- Insulin pen and pen needles
- Insulin Pump, supplies and copy of instruction manual
- Extra insulin cassettes/cartridges for insulin pump
- Back up insulin vial and syringes in case insulin

Pump is not properly functioning

- Fast- acting Glucose source (i.e., tablet/icing)
- Carbohydrate containing snacks
- Extra water bottles and juice for hydration
- Glucagon emergency kit with prescription label
- Beginning of each school year, new physician licensed healthcare provider's orders for the school health office to follow for appropriate care to be given

The last three pages are to be completed by the student's Physician/ Licensed Healthcare Provider

Physician/Licensed Healthcare Provider Plan of Care

(Must be completed be the Physician/Licensed Healthcare Provider)

Please write legibly to ensure quality care for our student

Diabetic Care Plan for: ____

(Student's Name)

Blood glucose Monitoring

Target for Blood Glucose monitoring:

☐ 70- 150mg/dl ☐ 70- 180mg/dl

☐Other __________to_________mg/dl Comment: ____

Usual times to check blood glucose ☐ Before lunch ☐ After lunch ☐ Other ______________________________

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

☐ Before exercise ☐ After exercise

OR when student exhibits symptoms of: ☐ Hyperglycemia ☐ Hypoglycemia

☐ Other: ____

May the student perform his/her own glucose checks? ☐ Yes ☐ No

Type of glucose meter student uses: ____

Sliding Scale Insulin

Is student using a sliding scale for insulin administration before lunch? ☐ Yes ☐ No

May use Sliding Scale Insulin every _______ to _______ hours? ☐ Yes ☐No

Blood Glucose:

BG < 100 mg/dl give ______units of ☐ Regular ______units of ☐ Humalog _____units of ☐ other _________________________

100- 149 mg/dl give ______units of ☐ Regular ______units of ☐ Humalog _____units of ☐ other _________________________

150- 199 mg/dl give ______units of ☐ Regular ______units of ☐ Humalog _____units of ☐ other _________________________

200- 249 mg/dl give ______units of ☐ Regular ______units of ☐ Humalog _____units of ☐ other _________________________

250- 299 mg/dl give ______units of ☐ Regular ______units of ☐ Humalog _____units of ☐ other _________________________

300- 349 mg/dl give ______units of ☐ Regular ______units of ☐ Humalog _____units of ☐ other _________________________

350-399 mg/dl give ______units of ☐ Regular ______units of ☐ Humalog _____units of ☐ other _________________________

BG >400 mg/dl give ______units of ☐ Regular ______units of ☐ Humalog _____units of ☐ other _________________________

Multiple Daily Injections- Insulin Therapy

Name of Insulin ____________________________________

Carbohydrate Coverage

Breakfast: 1 unit of insulin per____grams of carbohydrates
Lunch: 1 unit of insulin per____grams of carbohydrates
Dinner: 1 unit of insulin per____ grams of carbohydrates

1. **Correction for high blood sugar: Current Blood Sugar______ − mg/dl ÷ _____ = dose**
2. **Coverage for carbohydrate : Total grams of carbohydrate ÷ _____ = dose**
3. **Add doses together: Correction dose + carb dose**

***Please attach any additional information regarding insulin dose calculations used for this student**

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Meals and Snacks Eaten at School

	Time	**Food content/amount**
Breakfast	________	____________________
AM Snack	________	____________________
Lunch	________	____________________
PM Snack	________	____________________

Snack before exercise? ☐ Yes _______________________________________ ☐ No

Snack after exercise? ☐ Yes _______________________________________ ☐ No

Other times to give snacks: ____

A source of glucose, such as ___________________________________should be readily available at times.

Foods to avoid, if any ____

Instructions for when food is provided to class: i.e. class party or food sampling. ___________________________________

____

____

Hypoglycemia (Low Blood sugar)

Usual Symptoms for this student are

☐ Shaky ☐ Hungry ☐ Weak ☐ Sick to stomach
☐ Tired ☐ dizzy ☐ Sleepy ☐ Hard to think
☐ Pale ☐ Sweaty ☐ Headache
☐ Whiny ☐ Clumsy ☐ Glassy eyes

Treatment for Hypoglycemia ____
____

Glucagon should be given if student is unconscious,
Having convulsion or unable to swallow. **CALL 911**
Route _______________ Dosage_______________ Site ☐ Arm ☐ Thigh ☐ Other ____________________________________

Hyperglycemia (High Blood Sugar)

Usual symptoms for this student are

☐ Drinking more/very thirsty ☐ Headache ☐ Tired
☐ Increased urination ☐ Hunger

Treatment for Hyperglycemia: ____

Physician/ licensed Healthcare Provider note below orders:

1.) Student will be sent home when blood glucose level are 300mg/dl and above. If not, other level must be stated by physician or licensed healthcare provider. If other, state level ______________________mg/dl

2.) Urine will be checked for ketones when blood glucose levels are 300mg/dl and above. If not, other levels must be stated by physician or licensed healthcare provider.

3.) If other state level ______________________mg/dl

4.) Urine will be checked for ketones when blood glucose levels are 300mg/dl and above. If not, other levels must be stated by
physician or licensed healthcare provider. If checked at other level, state other level __________________mg/dl

5.) Student will be sent home if there is a trace of ketones or other ☐ Moderate ☐ Large

Antidiabetic Medications ☐ Yes ☐No

Medication, dose, route and schedule:
____

Other instructions:
____

Parent/Guardian may adjust student's insulin dosage independently of Physician or Licensed Healthcare Provider?

☐ Yes ☐No Comments: ____

For safety of our student, if able to use the injection pen, we request the use of an insulin pen, rather than drawing up insulin dosages. ☐ Yes ☐No

Please ensure that the patient has prescriptions for the below listed supplies as applicable. This will ensure appropriate care during the school year. <u>All applicable diabetic supplies listed are provided by parent/guardian throughout the school year.</u>

☐ Blood glucose meter, blood glucose test strips, batteries for meter, copy of the instruction manual and high/low calibration testing.

☐ Lancet device, lancets, gloves, etc.

☐ Urine ketone strips

☐ Insulin vials and syringes

☐ Insulin pen and pen needles

☐ Insulin Pump, supplies and copy of instruction manual

☐ Extra insulin cassettes/cartridges for insulin pump

☐ Back up insulin vial and syringes in case insulin
Pump is not properly functioning

☐ Glucagon emergency kit with prescription label

☐ Fast- acting Glucose source (i.e., tablet/icing)

☐ Carbohydrate containing snacks

☐ Extra water bottles and juice for hydration

☐ Beginning of each school year, new physician licensed healthcare provider's orders for the school health office to follow for appropriate care to be give

Signature ____ ________________________
(Student's Physician/License Healthcare Provider) Date

Print____
(Student's Physician/License Healthcare Provider)