### BLOOD GLUCOSE (BG) MONITORING

- **Before meals**
- **as needed for suspected low/high BG**
- **2 hours after correction**
- **Midmorning**
- **Mid-afternoon**

### INSULIN ADMINISTRATION

- Dose determined by: Student, Parent, School nurse or Trained Diabetes Personnel
- **Insulin delivery system:** Syringe, Pen, Pump

### 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 Type:
- Humalog Novolog Apidra

### Insulin to Carbohydrate Ratio:

<table>
<thead>
<tr>
<th>Type</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>MILD low sugar: Alert and cooperative student (BG below 70)</td>
<td>1 unit per 15 grams carbohydrate</td>
</tr>
<tr>
<td>SEVERE low sugar: Loss of consciousness or seizure</td>
<td>1 unit per 10 grams carbohydrate</td>
</tr>
</tbody>
</table>

- **Sliding Scale:**
  
  \[
  (BG - ____) \div _____ = \text{extra units insulin to provide}
  \]

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<th>Formula</th>
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<tr>
<td>MILD low sugar</td>
<td>BG from _____ to _____ = _____ u</td>
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<td>BG from _____ to _____ = _____ u</td>
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### 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, give **HALF** FULL correction formula noted above.
- If BG is greater than 300, and it’s been 4 hours since last dose, give 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.
- Child should be allowed to stay in school unless vomiting and moderate or large ketones are present.

### 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 70 mg/dl or above 300 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: call parent for care instructions

### SPECIAL MANAGEMENT OF INSULIN PUMP:

- Contact Parent in event of: pump alarms or malfunctions, detachment of dressing / infusion set out of 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 ___ hrs.
- Parents will provide extra supplies including infusion sets, reservoirs, batteries, pump insulin, and syringes.
This student requires assistance by the School Nurse or Trained Diabetes Personnel 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
- Provide other specified assistance: ____________________

This student may independently perform the following aspects of diabetes management:
- Monitor blood glucose:
  - in the classroom
  - in the designated clinic office
- in any area of the school and at any school related activity
- Monitor blood or urine 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

LOCATION OF SUPPLIES/EQUIPMENT: (To be completed by school personnel and parent. Parent to provide and restock snacks and low blood sugar supplies box.)

<table>
<thead>
<tr>
<th>Clinic room</th>
<th>With Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood glucose equipment</td>
<td>✔</td>
</tr>
<tr>
<td>Insulin administration supplies</td>
<td>✔</td>
</tr>
<tr>
<td>Ketone supplies</td>
<td>✔</td>
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<table>
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<tr>
<td>Glucagon kit</td>
<td>✔</td>
</tr>
<tr>
<td>Glucose gel</td>
<td>✔</td>
</tr>
<tr>
<td>Juice/low blood glucose snacks</td>
<td>✔</td>
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</tbody>
</table>

EMERGENCY NOTIFICATION: Notify parents of the following conditions:
a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon.
b. Blood sugars in excess of 300 mg/dl, when ketones present.
c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

Parent/Guardian: ___________________ Phone at Home: ___________ Work: ___________ Cell/Pager: ___________

Parent/Guardian: ___________________ Phone at Home: ___________ Work: ___________ Cell/Pager: ___________

Other emergency contact: ___________________ Phone #: ___________________ Relationship: ___________________

Insurance Carrier: ___________________ Preferred Hospital: ___________________ SIGNATURES:

I understand that all treatments and procedures may be performed by the student and/or Trained Diabetes Personnel within the school, or by EMS in the event of loss of consciousness or seizure. 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. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by Georgia state law.

PARENT SIGNATURE: ___________________ DATE: ___________________

SCHOOL NURSE SIGNATURE: ___________________ DATE: ___________________

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.

- Dose/treatment changes may be relayed through parent
- Student is due for medical appointment for review of diabetes management plan.

HEALTHCARE PROVIDER SIGNATURE: ___________________ Date: ________________

Diabetes Care Provider: ___________________ Phone #: ___________________

Address: ________________________________________________________________