

Parent Form
TUSD 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 Torrance 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
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Student's Parent/Guardian (please print)	Student's Parent/Guardian (signature)	Date
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Reviewed by School Nurse _____ (signature) _____ Date

Reviewed by Principal _____ (signature) _____ Date

Physician Form
TUSD DIABETES MEDICAL MANAGEMENT PLAN
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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

<i>Insulin Medication</i>	<i>Oral Medication</i>
<p><i>Pre-Breakfast:</i></p> <p style="text-align: center;">_____</p> <p style="text-align: center;"><i>Medication Amount Time</i></p>	<p style="text-align: center;">_____</p> <p style="text-align: center;"><i>Medication Amount Time</i></p>
<p><i>Pre-Bedtime</i></p> <p style="text-align: center;">_____</p> <p style="text-align: center;"><i>Medication Amount Time</i></p>	<p style="text-align: center;">_____</p> <p style="text-align: center;"><i>Medication Amount Time</i></p>
<p><i>Other</i></p> <p style="text-align: center;">_____</p> <p style="text-align: center;"><i>Medication Amount Time</i></p>	<p style="text-align: center;">_____</p> <p style="text-align: center;"><i>Medication Amount Time</i></p>

Snacks Ordered for School

<i>Snack</i>	<i>Time</i>	<i>Food Content/Amount</i>
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.***

Physician's Signature: _____ **Date:** _____

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

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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: 0.5 mg 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 _____ 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 & Parent Form
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Field Trips

The District Nurse MUST be notified two weeks before a field trip to plan and arrange for qualified personnel to provide medical care if necessary. All diabetic supplies including glucose tablets and snacks must be taken on every field trip as well as a cell phone or other means of communication to allow direct contact with the district nurse in case of problems. Care is provided according to this Diabetes Medical Management Plan and physician orders. Copies of these documents must be taken on the field trip. Juice, snacks, and Glucagon **MUST** be available to the student on all field trips or bus trips in case the student requires treatment for hypoglycemia. The driver/chaperone should know of any student with diabetes in their care in the event of an emergency.

Blood Glucose level must be tested 30 minutes before leaving for field trip.

If blood glucose is 80 or less, provide care for mild to moderate blood glucose. Provide snack containing 15 grams of rapid acting carbohydrate in addition to longer acting carbohydrate source. Retest in 20 minutes.

- ▶ On repeat test, if blood glucose is greater than 100, student may go on field trip. Take extra snacks along and retest blood sugar in 30 minutes.
- ▶ For safety when away from school, if blood glucose is less than 100, give additional 15 grams of carbohydrates and retest in 15 to 20 minutes. If greater than 100, child may go on field trip. If still less than 100, call parent.

If blood glucose is greater than 250

- Test urine for ketones
 Urine ketone testing not indicated

- ▶ If ketones are negative, trace or small (or testing is not indicated), have student drink extra water prior to leaving for field trip and take extra water along. It is okay for the student to go on the field trip. Ready access to restroom facilities will be needed.
- ▶ If ketones are moderate or large, call parent. Student may need additional insulin. Student should **NOT** go on field trip without physician authorization or parent and physician approval.
- ▶ Student should **NOT** go on field trip if other symptoms of illness are present (nausea, vomiting, abdominal pain, fever, etc).

Blood Glucose testing is not required prior to field trips.

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

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Supplies, Snacks, Medication & Equipment

<p>Daily Snacks (for am/pm snack times), Specify: _____</p> <p>Extra Snacks (for before, after and/or during exercise), Specify: _____</p> <p>Blood Glucose Meter Kit (Including meter, testing strips, and lancing device with lance) Brand/Model: _____</p> <p>Low Blood Glucose Supplies (5 day supply)</p> <ul style="list-style-type: none"> ☐ Fast Acting Carbohydrate Drinks (apple juice, orange juice, sugared soda NOT diet) at least 6 containers ☐ Glucose Tablets, 1 package or more ☐ Glucose Gel Products (Insta-Glucose, Monogel or Glucose/25-30 Gms.), 2 or more ☐ Gel Cakemate (not frosting) (19 Gms, mini-purse sized), 2 or more Note: Not used for emergency severe hypoglycemia ☐ Prepackaged Snacks (crackers with cheese or peanut butter, nite bite, etc), 5-6 servings or more <p>High Blood glucose Supplies</p> <ul style="list-style-type: none"> ☐ Ketone Test Strips – 1 Bottle ☐ Urine Cup ☐ Water Bottle 	<p>Insulin Supplies</p> <ul style="list-style-type: none"> ☐ Insulin Pen ☐ Pre-filled syringes (labeled per dose) ☐ Insulin and syringes <p>Extra Pump Supplies</p> <ul style="list-style-type: none"> ☐ Vial of insulin, syringes ☐ Pump Syringe ☐ Pump Tubing/Needle ☐ Batteries ☐ Tape, Soft-Serter <p>Emergency Supplies</p> <ul style="list-style-type: none"> ☐ Glucagon kit stored: _____ ☐ 3 day disaster food supply stored: _____ <p>3-Day Disaster Diabetes Supplies</p> <ul style="list-style-type: none"> ☐ Vial of insulin, 6 syringes ☐ Insulin pen with cartridge and needles ☐ Blood glucose testing kit (testing strips, lancing device with lancets) ☐ Glucose gel product and glucose tablets ☐ Glucagon kit ☐ Food supply (include daily meal plan) stored as follows: ☐ Ketone strips/plastic cup <p><u>Other supplies, specify:</u> _____</p>
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Physician's 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