

INFORMATION SHEET FOR THE SCHOOL MANAGEMENT OF DIABETES MELLITUS

School Year _____

Student's Name: _____ Date of Birth: _____ Effective Dates: _____
 School Name: _____ Grade _____ Homeroom _____

CONTACT INFORMATION

Parent/Guardian #1: _____ Phone Numbers: Home _____ Work _____ Cellular/Pager _____
 Parent/Guardian #2: _____ Phone Numbers: Home _____ Work _____ Cellular/Pager _____
 Diabetes Care Provider: _____ Phone Number _____
 Other Emergency Contact: _____ Relationship: _____ Phone Number: Home _____ Work/Cellular/Pager _____
 Insurance Carrier: _____ Preferred hospital: _____

EMERGENCY NOTIFICATION: Notify parents of the following conditions (If unable to reach parents: Notify diabetes care provider listed above:)

- a. Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.
- b. Blood sugars in excess of _____ mg/dl
- c. Positive urine ketones.
- d. Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, or altered level of consciousness.

MEALS/SNACKS: Time/Location	Food Content and Amount	Time/Location	Food Content and Amount
Breakfast _____	_____	MidAfternoon _____	_____
Midmorning _____	_____	Before PE/Activity _____	_____
Lunch _____	_____	After PE/Activity _____	_____

(Parent to provide and restock needed snacks)

BLOOD GLUCOSE MONITORING: At school: Yes No

To ordinarily be performed by student: Yes No Type of Meter: _____

Time to be performed: Before breakfast Before PE/Activity Time
 Midmorning: before snack After PE/Activity Time
 Before lunch Mid-afternoon
 Dismissal As needed for signs/symptoms of low/high blood glucose

Place to be performed: Clinic/Health Room Classroom Other _____

OPTIONAL: Target Range for blood glucose: _____ mg/dl to _____ mg/dl (Completed by diabetes care provider).

INSULIN INJECTIONS DURING SCHOOL: Yes No

If yes, can student determine correct dose? Yes No; Draw up correct dose? Yes No; Give own injection? Yes No

Insulin Delivery: Syringe/Vial Pen Pump (If pump worn, use "Supplemental Information Sheet for Student Wearing an Insulin Pump")

Routine daily insulin at school:

Type:	Dose:	Time to be given:
Humalog _____	_____	_____
Regular _____	_____	_____
NPH _____	_____	_____
Lente _____	_____	_____
Ultralente _____	_____	_____
Other _____	_____	_____

Extra Insulin for High Blood Sugar: Yes No

If yes, • Regular insulin or • Humalog

Time to be given: _____

Blood sugar: _____ Amount of Insulin: _____

Blood sugar: _____ Amount of Insulin: _____

Blood sugar: _____ Amount of Insulin: _____

Blood sugar: _____ Amount of Insulin: _____

Blood sugar: _____ Amount of Insulin: _____

OTHER ROUTINE DIABETES MEDICATIONS AT SCHOOL: • Yes • No

Name of Medication	Dose	Time	Route	Possible Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EXERCISE, SPORTS, AND FIELD TRIPS

Blood glucose monitoring and snacks as above.
 Easy access to sugar-free liquids, fast-acting carbohydrates, snacks, and blood glucose monitoring equipment.
 Child should not exercise if blood glucose level is below _____ mg/dl OR if _____

LOCATION OF SUPPLIES/EQUIPMENT: To be completed by school health personnel.

Blood glucose testing equipment: _____ Insulin administration supplies: _____
 Glucagon emergency kit: _____ Glucose gel: _____ Ketone testing supplies: _____
 Fast-acting carbohydrate: _____ Snack foods: _____

MANAGEMENT OF HIGH BLOOD GLUCOSE (over _____ mg/dl)

✓ Usual signs/symptoms for this student:

- Increased thirst, urination, appetite
- Tired/drowsy
- Blurred vision
- Warm, dry, or flushed skin
- Other _____

Indicate treatment choices:

- Sugar-free fluids as tolerated
- Check urine ketones if blood glucose over _____mg/dl
- Notify parent if urine ketones positive.
- May not need snack: **call parent**
- See **“Insulin Injections: Extra Insulin for High Blood Glucose”**
- Other _____

MANAGEMENT OF VERY HIGH BLOOD GLUCOSE (over _____ mg/dl)

✓ Usual signs/symptoms for this student

- Nausea/vomiting
- Abdominal pain
- Rapid, shallow breathing
- Extreme thirst
- Weakness/muscle aches
- Fruity breath odor
- Other _____

Indicate treatment choices:

- Sugar-free fluids if tolerated
- Check urine for ketones
- Notify parents per **“Emergency Notification” section**
- If unable to reach parents, call diabetes care provider
- Frequent bathroom privileges
- Stay with student and document changes in status
- Delay exercise.
- Other _____

MANAGEMENT OF LOW BLOOD GLUCOSE (below _____ mg/dl)

✓ Usual signs/symptoms for this child

- Change in personality/behavior
- Pallor
- Weak/shaky/tremulous
- Tired/drowsy/fatigued
- Dizzy/staggering walk
- Headache
- Rapid heartbeat
- Nausea/loss of appetite
- Clammy/sweating
- Blurred vision
- Inattention/confusion
- Slurred speech
- Loss of consciousness
- Seizures
- Other _____

Indicate treatment choices:

- If student is awake and able to swallow,***
- give _____ grams fast-acting carbohydrate such as:***
- 4oz. Fruit juice or non-diet soda or
- 3-4 glucose tablets or
- Concentrated gel or tube frosting or
- 8 oz. Milk or
- Other _____
- Retest BG 10-15minutes after treatment
- Repeat treatment until blood glucose over 80mg/dl
- Follow treatment with snack of _____
- if more than 1 hour till next meal/snack or if going to activity
- Other _____

IMPORTANT!!

If student is unconscious or having a seizure, presume the student is having a low blood glucose and:

Call 911 immediately and notify parents .

- **Glucagon _____mg should be given by trained personnel**
- **Glucose gel 1 tube can be administered inside cheek and massaged from outside while awaiting or during administration of Glucagon by any staff member at scene.**
- **Glucagon/Glucose gel could be used if student has documented low blood sugar and is vomiting or unable to swallow.**

Student should be turned on his/her side and maintained in this “recovery” position till fully awake”.

SIGNATURES

I/we understand that all treatments and procedures may be performed by the student and/or non-medical 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 have reviewed this information sheet and agree with the indicated instructions. This form will assist the school health personnel in developing a nursing care plan.

Parent’s Signature: _____ Date: _____

Physician’s Signature: _____ Date: _____

School Nurse’s Signature: _____ Date: _____

This document follows the guiding principles outlined by the American Diabetes Association

Revised August 13, 2001