Galichia
MEDICAL GROUP

School Plan

Need Updated Plan Yearly from Parent or Guardian

Fill out pages 1 & 2 then bring / send to Dr. Challans at least 2 weeks before school starts. Earlier If Possible.

OFFICE USE ONLY:

Patient Name:_____ Chart Number :_____ DOB:_____

Medical Management of Diabetes

TO BE COMPLETED BY PARENTS, SCHOOL NURSE AND HEALTH CARE PROVIDER

A non-nurse school employee may be designated and trained by the school nurse to provide the service(s).

If an emergency occurs and neither the school nurse nor the designee is available, 911 will be called.
This PSHCS will not be provided during transportation to / from school.

DIAGNOSIS – ❒ Type 1 Diabetes ❒ Type 2 Diabetes ❒ Pre Diabetes/Dysmetabolic Syndrome

Diabetes Care Plan for _____ School_____ Effective Date_____
(Name of Student)

Date of Birth_____ Age of Onset_____ Current Grade_____ School Phone#_____ School Fax#_____

School Nurse/Care Designee_____ Homeroom Teacher_____ Teacher Phone #_____

CONTACT INFORMATION

Parent/Guardian #1_____ Address_____

Telephone – Home _____ Work _____ Cell Phone_____

Parent/Guardian #2 _____ Address _____

Telephone – Home _____ Work _____ Cell Phone_____

Student's Doctor/Health Care Provider _____ Phone _____

Nurse Educator _____ Phone _____

Parent designee _____ Relationship _____

Telephone – Home _____ Work _____ Cell Phone_____

Hospital Choice _____ Known Allergies _____

BLOOD GLUCOSE MONITORING ___ No, will be managed at home.

Target range for blood glucose: 70 mg/dl to 180 mg/dl_____

TIMES TO TEST MUST BE CHECKED BELOW: Type of blood glucose meter used:_____

Usual times to check blood glucose per parent _____

____ mid-morning ____ before exercise/PE __x__ when student exhibits symptoms of hyperglycemia

____ pre-lunch ____ after exercise __x__ when student exhibits symptoms of hypoglycemia

____ mid-afternoon ___ other (explain): _____

Can student perform own blood glucose tests? _____ Yes _____ No Exceptions: significant hypoglycemia

Patient Name:_____ Chart Number :_____

DOB:_____

ROUTINE PRE-MEAL INSULIN – ____ No, will be managed at home. Supplemental Insulin on page 3.

BREAKFAST – give

_____units OR

_____units/_____grams of carbohydrates OR

_____units/_____calories

LUNCH – give

_____units OR

_____units/_____grams of carbohydrates OR

_____units/_____calories

TYPE Novolog, Humalog Apridra

Type Novolog, Humalog Apridra (may be interchanged)

Parent may direct insulin dose variation between _____ and _____ units without further orders.

Other (e.g., pre-lunch supplemental): _____

Home insulin – Type _____ Dose _____ Frequency _____

Can student give own injections? ___ Yes ___ No

Can student determine correct amount of insulin? ___ Yes ___ No

Can student draw correct dose of insulin? ___ Yes ___ No

FOR STUDENTS WITH INSULIN PUMPS

Type of pump _____ Is student competent regarding pump? ___Yes ___No

Insulin/carbohydrate ratio _____

Can student effectively troubleshoot problems (e.g. ketosis, pump malfunction)? ___Yes ___No

Correction factor _____

Comments_____

Change site after a bolus within 60 to 90 minutes IF – ketones do not resolve or blood glucose does not decrease

FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS – Medication _____

Time(s) _____ Side Effects _____

Other Medications_____

Time(s) _____ Side Effects_____

MEALS AND SNACKS EATEN AT SCHOOL

Is the student in high school? If so, can the high school student be responsible for meals and snacks during school?

___Yes ___No per parent

	Time	Food content / amount
Breakfast	_____	_____
A.M. snack	_____	optional _____
Lunch	_____	_____
P.M. snack	_____	optional_____

Other times to give snacks and content / amount _____

OFFICE USE ONLY:

Patient Name:_____ Chart Number :_____

Pages 3 & 4 will be filled out by Dr. Challans and his staff.

FOR HYPOGLYCEMIA – *When blood glucose is below* < 70

Common symptoms: shaky, sweaty, irritable, confusion _____

_____

Oral Treatment/Amount- 15-20 grams of quick-acting carbohydrate such as ½ c. juice, 1 c. milk, 4 glucose tablets, 6 oz. soda, 15 grams glucose gel

OTHER

_____

Recheck Blood Glucose 15 minutes following oral treatment. If blood glucose is still below 70, may repeat oral treatment and recheck blood glucose again in 15 minutes.

- If blood glucose is still below 70, repeat oral treatment and notify a parent or parent designee to pick up the student and care for him/her until blood glucose has been above 90 for at least 1 ½ hours.
- If blood glucose is above 70, follow with a protein snack. Student may return to class if he/she is not experiencing any symptoms of hypoglycemia.

Glucagon should be given if the student is unconscious, having a seizure, or is unable to swallow.

Glucagon Dose _____1 unit (1mg) _____ 1/2 unit (1/2 mg)

- ▶ Give Glucagon (School Nurse will administer Glucagon IM; designated trained school personnel will administer Glucagon SubQ).
- ▶ Call 911
- ▶ Notify parent or parent-designee (see page 1)
- ▶ Notify physician if unable to reach parent or parent-designee (see page 1)

FOR HYPERGLYCEMIA – *When blood glucose is above* _____ (always check for ketones)

NO exercise if any ketones or if blood glucose is > _____.

WHEN SUPPLEMENTAL INSULIN IS OR IS NOT ORDERED

A. If blood glucose is 250 or above with ketones, encourage water.
B. If blood glucose is 250-300 without ketones, encourage water and mild exercise.
C. If blood glucose is >300, with or without ketones, encourage water.
D. If blood glucose is >350 encourage water. Recheck in 60 minutes. If no supplemental insulin is ordered and blood glucose is still elevated, parent or parent-designees will be notified to pick student up from school and care for him/her until level is less than 300.

Patient Name:_____ Chart Number :_____

WHEN SUPPLEMENTAL AND/OR PRE-MEAL CORRECTION INSULIN IS GIVEN AT SCHOOL

Correction factor: Type of Insulin: _____

1 unit will decrease the blood glucose approximately _____mg. This child's target blood glucose is:_____.

Pre-meal correction insulin for hyperglycemia may be given when the blood glucose is greater than _____mg/dl.

SUPPLEMENTAL INSULIN— (Up to _____units SubQ) may be given for hyperglycemia when:

- Blood glucose is > 250 with ketones OR
- Greater than 300 mg/dl

  When supplemental insulin is given, blood glucose should always be rechecked in:

  - 120 minutes OR
  - in 60 minutes if:
    - large ketones OR
    - blood glucose is greater than 400
      - If blood glucose remains greater than 400 or ketones are still large, parents should be called to take child home until blood glucose is less than 300.
  - Supplemental insulin may be repeated in 120 minutes if:
    - blood glucose is greater than 250 mg/dl OR
    - ketones persist
      - After 2 treatments
        - If blood glucose remains greater than 350 or ketones are moderate or greater, parents should be called to take child home until BG is less than 300.

Children with diabetes need unrestricted access to the restroom and fluids and snacks available as needed. We also encourage minimal disruption to class and activity periods.

SIGNATURES

_____ Date _____

Phillip D Challans, MD

Office Phone # 316-684-3838 Fax Forms / Blood Sugars 316-858-2514

Supervising Physician: Phillip D Challans, MD

Physician emergency phone # if necessary 316-262-6262

Any amendments to this Medical Management for Diabetes must be in writing.
A new request must be completed annually AND when any amendment occurs.