

**Sample Diabetes Medical Management Plan** *Page 99*

**Sample Template for an Individualized Health Care Plan** *Page 107*

**Sample Emergency Care Plans for Hypoglycemia and Hyperglycemia** *Page 109*

Section 3 contains examples of three important tools for helping schools implement effective diabetes management—a sample Diabetes Medical Management Plan, a sample template for an Individualized Health Care Plan, and sample Emergency Care Plans for Hypoglycemia and Hyperglycemia.

- The **Diabetes Medical Management Plan (DMMP)** is completed by the student’s personal diabetes health care team and contains the medical orders that are the basis for the student’s health care and education plans.
- The **Individualized Health Care Plan (IHP)** is prepared by the school nurse and contains the strategies for implementing the medical orders in the DMMP in the school setting.
- The **Emergency Care Plans for Hypoglycemia and Hyperglycemia**, based on the DMMP, summarize how to recognize and treat hypoglycemia and hyperglycemia and who to contact for help. The school nurse will coordinate development of these plans. Emergency care plans should be completed for each student with diabetes and should be copied and distributed to all school personnel who have responsibility for students with diabetes during the school day and during school-sponsored activities. Provide completed copies to the parents/guardian as well.

## How to Use the Tools for Effective Diabetes Management

- The parents/guardian should give the sample Diabetes Medical Management Plan (DMMP) to the student's personal diabetes health care team as a resource for preparing the medical orders.
- The student's personal diabetes health care team should fill out the plan, sign it, review it with the parents/guardian and the student, and return it to the school nurse before the student with diabetes returns to school after diagnosis, or when the student transfers to a new school.
- The student's personal diabetes health care team should review and update the DMMP at the beginning of each school year or upon a change in the student's prescribed care regimen, level of self-management, school circumstances (e.g., a change in schedule), or at the request of the student or parents/guardian or the school nurse.
- The school nurse should prepare the Individualized Health Care Plan (IHP) based on the medical orders in the DMMP and review it with the parents/guardian and the student.
- The school nurse should adapt the sample Emergency Care Plans for Hypoglycemia and Hyperglycemia to meet the needs of individual students, as prescribed in the student's DMMP.
- The Emergency Care Plans should be copied and distributed to all regular and substitute personnel who have responsibility for the student with diabetes during the school day and during school-sponsored activities. Consider laminating these plans for use throughout the school year. Provide copies to the parents/guardian.
- During all levels of training, information in the Emergency Care Plans on the signs and symptoms of hypoglycemia and hyperglycemia, how to respond, and who to contact for help in an emergency should be reviewed with school personnel.

# Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of Plan: \_\_\_\_\_ This plan is valid for the current school year: \_\_\_\_\_ - \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Diabetes Diagnosis: \_\_\_\_\_  type 1  type 2  Other \_\_\_\_\_

School: \_\_\_\_\_ School Phone Number: \_\_\_\_\_

Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_

School Nurse: \_\_\_\_\_ Phone: \_\_\_\_\_

## CONTACT INFORMATION

Mother/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Student's Physician/Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Emergency Number: \_\_\_\_\_

Other Emergency Contacts:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_

## CHECKING BLOOD GLUCOSE

Target range of blood glucose:  70–130 mg/dL  70–180 mg/dL

Other: \_\_\_\_\_

Check blood glucose level:  Before lunch  \_\_\_\_\_ Hours after lunch

2 hours after a correction dose  Mid-morning  Before PE  After PE

Before dismissal  Other: \_\_\_\_\_

As needed for signs/symptoms of low or high blood glucose

As needed for signs/symptoms of illness

Preferred site of testing:  Fingertip  Forearm  Thigh  Other: \_\_\_\_\_

Brand/Model of blood glucose meter: \_\_\_\_\_

*Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.*

### Student's self-care blood glucose checking skills:

Independently checks own blood glucose

May check blood glucose with supervision

Requires school nurse or trained diabetes personnel to check blood glucose

**Continuous Glucose Monitor (CGM):**  Yes  No

Brand/Model: \_\_\_\_\_ Alarms set for:  (low) and  (high)

*Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.*

## HYPOGLYCEMIA TREATMENT

Student's usual symptoms of hypoglycemia (list below):

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If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than \_\_\_\_\_ mg/dL, give a quick-acting glucose product equal to \_\_\_\_\_ grams of carbohydrate.

Recheck blood glucose in 10–15 minutes and repeat treatment if blood glucose level is less than \_\_\_\_\_ mg/dL.

Additional treatment: \_\_\_\_\_

**HYPOGLYCEMIA TREATMENT** (Continued)

Follow physical activity and sports orders (see page 7).

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
- Glucagon:  1 mg  1/2 mg      Route:  SC  IM
- Site for glucagon injection:  arm  thigh  Other: \_\_\_\_\_
- Call 911 (Emergency Medical Services) and the student’s parents/guardian.
- Contact student’s health care provider.

**HYPERGLYCEMIA TREATMENT**

Student’s usual symptoms of hyperglycemia (list below):

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Check  Urine  Blood for ketones every \_\_\_\_\_ hours when blood glucose levels are above \_\_\_\_\_ mg/dL.

For blood glucose greater than \_\_\_\_\_ mg/dL AND at least \_\_\_\_\_ hours since last insulin dose, give correction dose of insulin (see orders below).

For insulin pump users: see additional information for student with insulin pump.

Give extra water and/or non-sugar-containing drinks (not fruit juices): \_\_\_\_\_ ounces per hour.

Additional treatment for ketones: \_\_\_\_\_

Follow physical activity and sports orders (see page 7).

- Notify parents/guardian of onset of hyperglycemia.
- If the student has symptoms of a hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911 (Emergency Medical Services) and the student’s parents/guardian.
- Contact student’s health care provider.

## INSULIN THERAPY

Insulin delivery device:  syringe  insulin pen  insulin pump

### Type of insulin therapy at school:

- Adjustable Insulin Therapy  
 Fixed Insulin Therapy  
 No insulin

### Adjustable Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:**

Name of insulin: \_\_\_\_\_

- **Carbohydrate Coverage:**

Insulin-to-Carbohydrate Ratio:

Lunch: 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

Snack: 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

### Carbohydrate Dose Calculation Example

$$\frac{\text{Grams of carbohydrate in meal}}{\text{Insulin-to-carbohydrate ratio}} = \text{_____ units of insulin}$$

- **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor = \_\_\_\_\_

Target blood glucose = \_\_\_\_\_ mg/dL

### Correction Dose Calculation Example

$$\frac{\text{Actual Blood Glucose} - \text{Target Blood Glucose}}{\text{Blood Glucose Correction Factor/Insulin Sensitivity Factor}} = \text{_____ units of insulin}$$

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL give \_\_\_\_\_ units

Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL give \_\_\_\_\_ units

Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL give \_\_\_\_\_ units

Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL give \_\_\_\_\_ units

**INSULIN THERAPY** (Continued)

**When to give insulin:**

Lunch

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_\_ hours since last insulin dose.
- Other: \_\_\_\_\_

Snack

- No coverage for snack
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_\_ hours since last insulin dose.
- Other: \_\_\_\_\_

Correction dose only:

For blood glucose greater than \_\_\_\_\_ mg/dL AND at least \_\_\_\_\_ hours since last insulin dose.

Other: \_\_\_\_\_

**Fixed Insulin Therapy**

Name of insulin: \_\_\_\_\_

- \_\_\_\_\_ Units of insulin given pre-lunch daily
- \_\_\_\_\_ Units of insulin given pre-snack daily
- Other: \_\_\_\_\_

**Parental Authorization to Adjust Insulin Dose:**

- Yes  No Parents/guardian authorization should be obtained before administering a correction dose.
- Yes  No Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- \_\_\_\_\_ units of insulin.
- Yes  No Parents/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: \_\_\_\_\_ units per prescribed grams of carbohydrate, +/- \_\_\_\_\_ grams of carbohydrate.
- Yes  No Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- \_\_\_\_\_ units of insulin.

**INSULIN THERAPY** (Continued)

**Student's self-care insulin administration skills:**

- Yes  No Independently calculates and gives own injections
- Yes  No May calculate/give own injections with supervision
- Yes  No Requires school nurse or trained diabetes personnel to calculate/give injections

**ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP**

Brand/Model of pump: \_\_\_\_\_ Type of insulin in pump: \_\_\_\_\_

Basal rates during school: \_\_\_\_\_

Type of infusion set: \_\_\_\_\_

- For blood glucose greater than \_\_\_\_\_ mg/dL that has not decreased within \_\_\_\_\_ hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.
- For infusion site failure: Insert new infusion set and/or replace reservoir.
- For suspected pump failure: suspend or remove pump and give insulin by syringe or pen.

**Physical Activity**

- May disconnect from pump for sports activities  Yes  No
- Set a temporary basal rate  Yes  No \_\_\_\_\_% temporary basal for \_\_\_\_\_ hours
- Suspend pump use  Yes  No

**Student's self-care pump skills:**

- Count carbohydrates
- Bolus correct amount for carbohydrates consumed
- Calculate and administer correction bolus
- Calculate and set basal profiles
- Calculate and set temporary basal rate
- Change batteries
- Disconnect pump
- Reconnect pump to infusion set
- Prepare reservoir and tubing
- Insert infusion set
- Troubleshoot alarms and malfunctions

**Independent?**

- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No



## OTHER DIABETES MEDICATIONS

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Times given: \_\_\_\_\_  
 Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Times given: \_\_\_\_\_

## MEAL PLAN

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast	_____	_____ to _____
Mid-morning snack	_____	_____ to _____
Lunch	_____	_____ to _____
Mid-afternoon snack	_____	_____ to _____

Other times to give snacks and content/amount: \_\_\_\_\_

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): \_\_\_\_\_

Special event/party food permitted:  Parents/guardian discretion  
 Student discretion

### Student's self-care nutrition skills:

- Yes  No Independently counts carbohydrates  
 Yes  No May count carbohydrates with supervision  
 Yes  No Requires school nurse/trained diabetes personnel to count carbohydrates

## PHYSICAL ACTIVITY AND SPORTS

A quick-acting source of glucose such as  glucose tabs and/or  sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat  15 grams  30 grams of carbohydrate  other \_\_\_\_\_  
 before  every 30 minutes during  after vigorous physical activity  
 other \_\_\_\_\_

If most recent blood glucose is less than \_\_\_\_\_ mg/dL, student can participate in physical activity when blood glucose is corrected and above \_\_\_\_\_ mg/dL.

Avoid physical activity when blood glucose is greater than \_\_\_\_\_ mg/dL or if urine/blood ketones are moderate to large.

(Additional information for student on insulin pump is in the insulin section on page 6.)

## DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.

- Continue to follow orders contained in this DMMP.
- Additional insulin orders as follows: \_\_\_\_\_
- Other: \_\_\_\_\_

## SIGNATURES

This Diabetes Medical Management Plan has been approved by:

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Student's Physician/Health Care Provider Date

I, (parent/guardian:) \_\_\_\_\_ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school:) \_\_\_\_\_ to perform and carry out the diabetes care tasks as outlined in (student:) \_\_\_\_\_'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

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Acknowledged and received by:

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Student's Parent/Guardian Date

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Student's Parent/Guardian Date

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School Nurse/Other Qualified Health Care Personnel Date

# Individualized Health Care Plan (IHP)

Student: \_\_\_\_\_

Grade: \_\_\_\_\_

Dates: \_\_\_\_\_

School Year: \_\_\_\_\_

IHP Completed by and Date: \_\_\_\_\_

IHP Review Dates: \_\_\_\_\_

Nursing Assessment Review: \_\_\_\_\_

Nursing Assessment Completed by and Date: \_\_\_\_\_

Nursing Diagnosis	Sample Interventions and Activities	Date Implemented	Sample Outcome Indicator	Date Evaluated										
<p><b>Managing Potential Diabetes Emergencies</b></p> <p>(risk for unstable blood glucose)</p>	<p>Establish and document student's routine for maintaining blood glucose within goal range including while at school:</p> <p><b>Blood Glucose Monitoring</b></p> <ul style="list-style-type: none"> <li>• Where to check blood glucose:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Classroom</li> <li><input type="checkbox"/> Health room</li> <li><input type="checkbox"/> Other</li> </ul> </li> <li>• When to check blood glucose:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Before breakfast</li> <li><input type="checkbox"/> Mid-morning</li> <li><input type="checkbox"/> Before lunch</li> <li><input type="checkbox"/> After lunch</li> <li><input type="checkbox"/> Before snack</li> <li><input type="checkbox"/> Before PE</li> <li><input type="checkbox"/> After PE</li> <li><input type="checkbox"/> 2 hours after correction dose</li> <li><input type="checkbox"/> Before dismissal</li> <li><input type="checkbox"/> As needed</li> <li><input type="checkbox"/> Other: _____</li> </ul> </li> <li>• Student Self-Care Skills:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Independent</li> <li><input type="checkbox"/> Supervision</li> <li><input type="checkbox"/> Full assistance</li> </ul> </li> <li>• Brand/model of BG meter: _____</li> <li>• Brand/model of CGM: _____</li> </ul>		<p><b>Blood glucose remains in goal range</b></p> <p>Percentage of Time</p> <table border="1" data-bbox="1052 919 1386 982"> <tr> <td>0%</td> <td>25%</td> <td>50%</td> <td>75%</td> <td>100%</td> </tr> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> </table>	0%	25%	50%	75%	100%	1	2	3	4	5	
0%	25%	50%	75%	100%										
1	2	3	4	5										

# Individualized Health Care Plan (IHP) (Continued)

Nursing Diagnosis	Sample Interventions and Activities	Date Implemented	Sample Outcome Indicator	Date Evaluated										
<p><b>Supporting the Independent Student</b> (effective therapeutic regimen management)</p>	<p><b>Hypoglycemia Management</b> <b>STUDENT WILL:</b></p> <ul style="list-style-type: none"> <li>• Check blood glucose when hypoglycemia suspected</li> <li>• Treat hypoglycemia (follow Diabetes Emergency Care Plan)</li> <li>• Take action following a hypoglycemia episode: _____</li> <li>• Keep quick-acting glucose product to treat on the spot Type: _____ Location: _____</li> <li>• Routinely monitor hypoglycemia trends r/t class schedule (e.g., time of PE, scheduled lunch, recess) and insulin dosing</li> <li>• Report and consult with parents/guardian, school nurse, HCP, and school personnel as appropriate</li> </ul>		<p><b>Monitors Blood Glucose</b> (records, reports, and correctly responds to results)</p> <table border="1"> <tr> <td>Never Demonstrated</td> <td></td> <td></td> <td></td> <td>Consistently Demonstrated</td> </tr> <tr> <td><b>1</b></td> <td><b>2</b></td> <td><b>3</b></td> <td><b>4</b></td> <td><b>5</b></td> </tr> </table>	Never Demonstrated				Consistently Demonstrated	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	
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<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>										
<p><b>Supporting Positive Coping Skills</b> (readiness for enhanced coping)</p>	<p><b>Environmental Management</b></p> <ul style="list-style-type: none"> <li>• Ensure confidentiality</li> <li>• Discuss with parents/guardian and student preference about who should know student's coping status at school</li> <li>• Collaborate with parents/guardian and school personnel to meet student's coping needs</li> <li>• Collaborate with school personnel to create an accepting and understanding environment</li> </ul>		<p><b>Readiness to Learn</b></p> <table border="1"> <tr> <td>Severely Compromised</td> <td></td> <td></td> <td></td> <td>Not Compromised</td> </tr> <tr> <td><b>1</b></td> <td><b>2</b></td> <td><b>3</b></td> <td><b>4</b></td> <td><b>5</b></td> </tr> </table>	Severely Compromised				Not Compromised	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	
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<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>										

# Hypoglycemia Emergency Care Plan

(For Low Blood Glucose)

Student's Name: \_\_\_\_\_

Grade/Teacher: \_\_\_\_\_

Date of Plan: \_\_\_\_\_

## Emergency Contact Information

Mother/Guardian: \_\_\_\_\_

Email address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_

Email address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_

Phone number: \_\_\_\_\_

School Nurse: \_\_\_\_\_

Contact number(s): \_\_\_\_\_

Trained Diabetes Personnel: \_\_\_\_\_

Contact number(s): \_\_\_\_\_

**The student should never be left alone, or sent anywhere alone, or with another student, when experiencing hypoglycemia.**

Causes of Hypoglycemia	Onset of Hypoglycemia
<ul style="list-style-type: none"><li>• Too much insulin</li><li>• Missing or delaying meals or snacks</li><li>• Not eating enough food (carbohydrates)</li><li>• Getting extra, intense, or unplanned physical activity</li><li>• Being ill, particularly with gastrointestinal illness</li></ul>	<ul style="list-style-type: none"><li>• Sudden—symptoms may progress rapidly</li></ul>

## Hypoglycemia Symptoms

Circle student's usual symptoms.

Mild to Moderate		Severe
<ul style="list-style-type: none"> <li>• Shaky or jittery</li> <li>• Sweaty</li> <li>• Hungry</li> <li>• Pale</li> <li>• Headache</li> <li>• Blurry vision</li> <li>• Sleepy</li> <li>• Dizzy</li> <li>• Confused</li> <li>• Disoriented</li> </ul>	<ul style="list-style-type: none"> <li>• Uncoordinated</li> <li>• Irritable or nervous</li> <li>• Argumentative</li> <li>• Combative</li> <li>• Changed personality</li> <li>• Changed behavior</li> <li>• Inability to concentrate</li> <li>• Weak</li> <li>• Lethargic</li> <li>• Other: _____</li> </ul>	<ul style="list-style-type: none"> <li>• Inability to eat or drink</li> <li>• Unconscious</li> <li>• Unresponsive</li> <li>• Seizure activity or convulsions (jerking movements)</li> </ul>

## Actions for Treating Hypoglycemia

Notify School Nurse or Trained Diabetes Personnel as soon as you observe symptoms.

If possible, check blood glucose (sugar) at fingertip.

Treat for hypoglycemia if blood glucose level is less than \_\_\_\_mg/dL.

**WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.**

Treatment for Mild to Moderate Hypoglycemia	Treatment for Severe Hypoglycemia
<ul style="list-style-type: none"> <li>• Provide quick-acting glucose (sugar) product equal to _____ grams of carbohydrates. Examples of 15 grams of carbohydrates include:               <ul style="list-style-type: none"> <li>○ 3 or 4 glucose tablets</li> <li>○ 1 tube of glucose gel</li> <li>○ 4 ounces of fruit juice (not low-calorie or reduced sugar)</li> <li>○ 6 ounces of soda (½ can) (not low-calorie or reduced sugar)</li> </ul> </li> <li>• Wait 10 to 15 minutes.</li> <li>• Recheck blood glucose level.</li> <li>• Repeat quick-acting glucose product if blood glucose level is less than ____mg/dL.</li> <li>• Contact the student's parents/guardian.</li> </ul>	<ul style="list-style-type: none"> <li>• Position the student on his or her side.</li> <li>• Do not attempt to give anything by mouth.</li> <li>• Administer glucagon: _____ mg at _____ site.</li> <li>• While treating, have another person call 911 (Emergency Medical Services).</li> <li>• Contact the student's parents/guardian.</li> <li>• Stay with the student until Emergency Medical Services arrive.</li> <li>• Notify student's health care provider.</li> </ul>

# Hyperglycemia Emergency Care Plan

(For High Blood Glucose)

Student's Name: \_\_\_\_\_

Grade/Teacher: \_\_\_\_\_

Date of Plan: \_\_\_\_\_

## Emergency Contact Information

Mother/Guardian: \_\_\_\_\_

Email address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_

Email address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_

Phone number: \_\_\_\_\_

School Nurse: \_\_\_\_\_

Contact number(s): \_\_\_\_\_

Trained Diabetes Personnel: \_\_\_\_\_

Contact number(s): \_\_\_\_\_

Causes of Hyperglycemia	Onset of Hyperglycemia
<ul style="list-style-type: none"><li>• Too little insulin or other glucose-lowering medication</li><li>• Food intake that has not been covered adequately by insulin</li><li>• Decreased physical activity</li><li>• Illness</li><li>• Infection</li><li>• Injury</li><li>• Severe physical or emotional stress</li><li>• Pump malfunction</li></ul>	<ul style="list-style-type: none"><li>• Over several hours or days</li></ul>

## Hyperglycemia Signs

## Hyperglycemia Emergency Symptoms

(Diabetic Ketoacidosis, DKA, which is associated with hyperglycemia, ketosis, and dehydration)

Circle student's usual signs and symptoms.

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Increased thirst and/or dry mouth</li> <li>• Frequent or increased urination</li> <li>• Change in appetite and nausea</li> <li>• Blurry vision</li> <li>• Fatigue</li> <li>• Other: _____</li> </ul> | <ul style="list-style-type: none"> <li>• Dry mouth, extreme thirst, and dehydration</li> <li>• Nausea and vomiting</li> <li>• Severe abdominal pain</li> <li>• Fruity breath</li> <li>• Heavy breathing or shortness of breath</li> <li>• Chest pain</li> <li>• Increasing sleepiness or lethargy</li> <li>• Depressed level of consciousness</li> </ul> |
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## Actions for Treating Hyperglycemia

Notify School Nurse or Trained Diabetes Personnel as soon as you observe symptoms.

### Treatment for Hyperglycemia

### Treatment for Hyperglycemia Emergency

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Check the blood glucose level: _____ mg/dL.</li> <li>• Check urine or blood for ketones if blood glucose levels are greater than: _____ mg/dL.</li> <li>• If student uses a pump, check to see if pump is connected properly and functioning.</li> <li>• Administer supplemental insulin dose: _____.</li> <li>• Give extra water or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.</li> <li>• Allow free and unrestricted access to the restroom.</li> <li>• Recheck blood glucose every 2 hours to determine if decreasing to target range of _____ mg/dL.</li> <li>• Restrict participation in physical activity if blood glucose is greater than _____ mg/dL and if ketones are moderate to large.</li> <li>• Notify parents/guardian if ketones are present.</li> </ul> | <ul style="list-style-type: none"> <li>• Call parents/guardian, student's health care provider, and 911 (Emergency Medical Services) right away.</li> <li>• Stay with the student until Emergency Medical Services arrive.</li> </ul> |
|---|---|