H.O.N.D.S.℠
HELPING ADMINISTER TO THE NEEDS OF THE STUDENT WITH DIABETES IN SCHOOL

DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL

Effective Date: _____

Student: _____ **DOB:** _____

Student ID#: _____ **School:** _____

Type of Diabetes: ☐ **Type 1** ☐ **Type 2** **Date of Diagnosis:** _____

☐ Other: _____

Blood glucose Monitoring

☐ Meter Type: _____ ☐ **Blood glucose target range: _____-_____ mg/dl**

☐ Blood glucose monitoring times: _____

☐ For suspected hypoglycemia ☐ At student's discretion excluding suspected hypoglycemia

☐ No blood glucose monitoring at school ☐ Supervision of monitoring and results

☐ Permission to monitor independently

☐ Assistance with monitoring and results.

☐ Check blood glucose 10 to 20 minutes before boarding bus.

Diabetes Medication

☐ No insulin at school: Current insulin at home: _____

☐ Oral diabetes medication at school: _____

☐ Insulin at school: ☐ Humalog ☐ Novolog ☐ Apidra ☐ Other: _____

Insulin delivery device: ☐ Syringe and vial ☐ Insulin pen ☐ Insulin pump

Insulin dose for school: _____

Standard lunchtime dose: _____

☐ Meal bolus: _____ units of insulin per _____ grams of carbohydrate.

☐ Correction for blood glucose: _____ units of insulin for every _____ md/dl above _____ mg/dl.

(Correction bolus can be given with meals or every 3 hours if blood glucose levels are high)

Correction Scale

Blood Glucose Value (mg/dl)	Units of Insulin
Less than 100	
100-150	
151-200	
201-250	
251-300	
301-350	
352-400	
More than 400	

Note: Insulin dose is a total of meal bolus and correction bolus.

☐ Parent/Guardian máy adjust insulin doses within the following range: _____

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Meal Plan

1 carbohydrate choice = _____ Grams of carbohydrate

☐ Meal plan prescribed (see below) ☐ Meal plan variable

Breakfast Time: _____ # of carb choices = _____

Morning Snack Time: _____ # of carb choices = _____

Lunch Time: _____ # of carb choices = _____

Afternoon Snack Time: _____ # of carb choices = _____

☐ Plan for pre-activity: _____

☐ Plan for after school activities: _____

☐ Plan for class parties: _____

☐ Extra food allowed: ☐ Parent/guardian's discretion ☐ Student's discretion

Hypoglycemia

Blood Glucose < _____ mg/dl

☐ Self treatment of mild lows ☐ Assistance for all lows

☐ Immediately treat with 15 gm of fast-acting carbohydrate (e.g.; 4 oz juice, 3-4 glucose tabs, 6oz regular soda, 3 tsp glucose gel)

☐ Recheck blood glucose in 15 minutes and repeat 15 gm of carbohydrate if blood glucose remains low.

☐ If more than 1 hour until next meal or snack student should have another 15 gm of carbohydrate.

☐ If child will be participating in additional exercise or activity before the next meal, provide an additional carbohydrate choice.

☐ If student is using an insulin pump, suspend pump until blood glucose is back in goal range.

Severe Hypoglycemia

If the child is unconscious or having seizures due to low blood glucose immediately administer injection of: **Glucagon _____ mg (glucagon emergency kit)**

- Immediately after administering the Glucagon, turn the student onto their side. Vomiting is a common side effect of Glucagon.
- Notify parent/guardian and EMS per protocol

Hyperglycemia

Blood Glucose > _____ mg/dl

☐ Check ketones when blood glucose > _____ mg/dl or student is sick.

☐ Use Correction Scale insulin orders when blood glucose is _____ mg/dl.

☐ Unlimited bathroom pass.

☐ Notify parent immediately of blood glucose > _____ mg/dl or if student is vomiting.

☐ If student is using an insulin pump, follow DKA prevention protocol

Special Occasions

☐ Arrange for appropriate monitoring and access to supplies on all field trips.

_____
Signature of Physician/Licensed Prescriber Date

_____
Print name of Physician/Licensed Prescriber

_____ _____ _____
Clinic Address Phone Fax

Returned to:

_____ _____ _____
RN, School Nurse Phone Fax

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Student: _____
DOB: _____
Student ID #: _____

DIABETES QUESTIONNAIRE

Please complete and return to the School Nurse.
The following information is helpful in determining any special needs. School year: _____

Person to contact:	Relationship:	Work Phone:	Home Phone:
1.			
2.			

Preferred Communication method: ☐ Phone ☐ Written ☐ In Person ☐ Email: _____

Health Care Provider	Clinic:	Phone:

Hospital:	Phone:

Child's age at diagnosis of diabetes: _____

Does your child wear a medical alert bracelet/necklace? ☐ Yes ☐ No

Will your child need routine snacks at school? ☐ A.M. ☐ P.M. ☐ as needed
(Snacks will need to be provided by the family)
What would you like done about birthday treats and/or party snacks? _____

What time should your child's blood sugar be monitored? ☐ A.M. ☐ P.M. ☐ as needed
(Authorization by a health care provider is required.) ☐ not needed

Does your child know how to check his/her own blood sugar? ☐ Yes ☐ No

Will your child need to test his/her urine for ketones at school? ☐ Yes ☐ No

Will your child need to test his/her blood for ketones at school? ☐ Yes ☐ No

What blood sugar level is considered low for your child? below _____

How often does your child typically experience low blood sugar? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

When does he/she typically experiences low blood sugar:
☐ mid A.M. ☐ before lunch ☐ afternoon ☐ after exercise ☐ other _____

Please check your child's usual signs/symptoms of low blood sugar.

☐ hunger or "butterfly feeling"	☐ irritable	☐ difficulty with speech
☐ shaky/trembling	☐ weak/drowsy	☐ difficulty with coordination
☐ dizzy	☐ inappropriate crying or laughing	☐ confused/disoriented
☐ sweaty	☐ severe headache	☐ loss of consciousness
☐ rapid heartbeat	☐ impaired vision	☐ seizure activity
☐ pale	☐ anxious	☐ other

Does he/she recognize these signs/symptoms? ☐ Yes ☐ No

In the past year, how often has your child been treated for severe low blood sugar? _____

In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital ☐

In the past year, how often has your child been treated for severe high blood sugar or diabetic ketoacidosis? _____

In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital ☐

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DIABETES QUESTIONNAIRE

What do you usually do to treat low blood sugar at home? Please be specific and state exact amount of food, beverage, glucagon, etc. (All supplies must be provided by the family if needed at school.) _____
Please indicate your child's skill level for the following:

Skill	Does alone	Does with help	Done by adult	Comments
Obtain glucose sample				
Reads meter and records				
Counts carbs for meals/snack				
Interprets sliding scale				
Selects insulin injection site				
Measures insulin				
Administers insulin				
Measures ketones				
Pump skills				

Insulin taken on a regular basis:

Name	Type	Units	Time of day	Delivery Method (Pen, syringe, pump)

Does your child use an insulin to carbohydrate ratio? Yes ☐ No ☐ Ratio: _____

Does your child adjust the insulin dose for high or low blood sugar? Yes ☐ No ☐ Correction factor (insulin sensitivity): _____

Other medication taken on regular basis:

Name	By (mouth, injection, etc)	Dose	Time of Day

As needed medication:

Name	By (mouth, injection, etc)	Dose	Time of Day

Please list any known medication side effects that may affect your child's learning and/or behavior:

_____
_____

If a medication is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of medication if the student is deemed capable. The medication must be in the original labeled container. When you get the prescription filled, please ask the pharmacist to put it into two containers so the student will have one for school and one for home use.

What action do you want school personnel to take if your child's does not respond to treatment/medication?

_____
_____

In an acute emergency, the student will be transported by paramedics to the hospital. Transportation in a non-acute situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

Has your child received diabetes education? ☐ by health care provider ☐ at support group ☐ at camp ☐ other

Please add anything else that you would like school personnel to know about your child's diabetes (or related health conditions).

_____
_____

Information was provided by _____ (Name) _____ (Relationship to Student) _____ (Date)

I authorize reciprocal release of information related to diabetes mellitus between the school nurse and the health care provider.

_____ (Parent/Guardian) _____ (Date)