Weimar Independent School District
Diabetes Medical Management Plan

Name: _____ DOB: _____ ID#: _____

School: _____ Grade/Teacher: _____ School Year: _____

Diagnosis: Type I Diabetes Mellitus

Procedures: (parent to provide supplies for all procedures)

a. Test blood before lunch and as needed for signs/symptoms of hypoglycemia and/or illness.

b. Test urine ketones when blood glucose is over 250 mg/dl and/or when the child is ill.

c. Please circle type of insulin: _____Regular _____Humalog _____Novolog _____Apidra

☐ Insulin to Carbohydrate Ratio: _____ unit of insulin per _____ grams of carbohydrate plus correction scale prior to lunch

☐Fixed dose: _____ units of insulin plus correction scale prior to lunch

Correction Scale: For BG below _____ no additional insulin

For Blood Glucose ranging form	To	Give this much extra insulin
BG _____	BG _____	BG _____
BG _____	BG _____	BG _____
BG _____	BG _____	BG _____
BG _____	BG _____	BG _____

Notify parent if blood glucose is over _____

☐ **Insulin Pump** - Insulin to Carbohydrate Ratio: ____ unit of insulin per ____ grams of carbohydrate prior to lunch or snack (Correction dose calculated by insulin pump).

d. Child to eat lunch following pre-lunch test and insulin administration.

Precautions:

a. **HYPOGLYCEMIA (< 70 mg/dl)**: Signs of hypoglycemia include trembling, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma or seizures. See treatment chart on the following page.

b. **HYPERGLYCEMIA (> 250 mg/dl)**: Signs include frequency of urination and excessive thirst. See the treatment chart on the following page. (Note: Deep rapid respirations combined with a fruity odor to the breath and positive urinary ketones are signs of ketoacidosis. This is an emergency. Notify parent/guardian.

Meal Plan:
Breakfast: _____ carbohydrate grams
Mid AM Snack: _____ carbohydrate grams
Lunch: _____ carbohydrate grams
Mid PM Snack: _____ carbohydrate grams

Name: _____ DOB: _____ ID#: _____

GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

If blood glucose is 70 to 250 mg/dl, follow the usual meal plan, ordered lunch time insulin, and daily activities unless otherwise directed.

Hypoglycemia Treatment Plan:

If blood glucose is BELOW 70 mg/dl and child is alert and able to swallow:

A. Give 15 grams carbohydrate (CHO), examples include but are not limited to:
- 6 lifesavers
- 4 ounces of juice
- 6 ounces regular soda (not diet)
- 4 glucose tablets

B. Allow child to rest 10 to 15 minutes and retest blood glucose

C. If blood glucose remains below 70 mg/dl, repeat A and B

D. After 3rd treatment for blood glucose and level remains below 70 mg/dl, contact parent

E. If it is snack or lunch time, allow child to eat snack or meal

Insulin pump: Suspend pump after 2nd treatment if glucose is < 70 mg/dl. Resume pump when >70 mg/dl. Notify parent/guardian as needed.

If blood glucose is BELOW 70 mg/dl and the child is unconscious or seizing:

A. Enact school emergency response plan – Call 911 and notify parents

B. If available: inject Glucagon _____ mg subcutaneously

C. If seizing, follow seizure protocol.

Hyperglycemia Treatment Plan:

If blood glucose is OVER 250 mg/dl:

A. Test urine for ketones.

B. If ketones are NEGATIVE:
- Child may participate in usual activities.
- Encourage water or calorie-free liquids.
- Allow access to restroom.
- If meal time, follow insulin orders and usual meal plan.

C. If ketones are POSITIVE (small, moderate or large):
- Encourage water or calorie-free liquids.
- If occurring at lunch-time, give insulin per orders.
- Retest glucose and ketones every 2 hours, or until ketones are negative.
- No physical activity until ketones are negative.
- Notify parents if blood glucose if over 400 mg/dl, large ketones, nausea/vomiting, deep rapid respirations and/or fruity odor to the breath.

Insulin pump: Notify parent/guardian of high glucose, moderate or large ketones and/or no improvement within two hours following intervention.

Physician Consent for Self Administration of Diabetes Care

I have instructed the student named here in the proper procedure for diabetes care. It is my professional opinion that this student ☐ should / ☐ should not (check one) be allowed to carry and perform the tasks related to diabetes while on school
property or at school-related events. **Physician Initials** _____

Physician Consent for Care by Unlicensed Diabetes Care Assistant

Per Texas House Bill 984, a “Diabetes Care Assistant” designated by the principal and instructed in diabetes care, may administer diabetes treatments, medication or procedures if a licensed healthcare professional is not available.

Physician's Name: _____ Phone: _____
Physician's Signature: _____ Date: _____
Name: _____ DOB: _____ ID#: _____

PARENT/PROVIDER ASSESSMENT OF STUDENT'S DIABETES SELF-MANAGEMENT SKILLS

Skills: Insulin per Syringe, Pen, Vial and Syringe	**Independent with Diabetes Skills and Management**	**Requires Supervision**	**Requires Assistance**	**Dependent on Trained Personnel for Diabetes Care**
Preparing insulin				
Giving injection				
Performing glucose testing				
Performing ketone testing				
Calculating carbohydrate/insulin ratio				
Recognizing/treating hypoglycemia and/or hyperglycemia				

Skills: Insulin Pump	**Independent with Diabetes Skills and Management**	**Requires Supervision**	**Requires Assistance**	**Dependent on Trained Personnel for Diabetes Care**
Calculating/administering insulin bolus and correction dose				
Problem solving with hyperglycemia				
Using SQ injections when indicated by DMMP				
Priming/inserting catheter or pod				
Performing glucose testing				
Performing ketone testing				
Calculating carbohydrates				
Recognizing and treating hypoglycemia/hyperglycemia				
Troubleshoot alarms and malfunctions				

Parent Consent for Self Administration of Diabetes Care

I, the parent of the student named here, ☐ do / ☐ do not (check one) agree with his/her physician to allow my child to carry and perform the tasks necessary for diabetes care. If my child carries her/her own, I realize that the school clinic will not have his/her personal

diabetes equipment unless I supply the school with an extra one in case my child forgets his/hers. I understand that the school nurse will also assess my child's knowledge and ability to identify symptoms and self-administer diabetes care.

Parent Initials _____

Name: _____ DOB: _____ ID#: _____

Parent/Guardian Consent for Unlicensed Assistive Personnel to Administer Diabetes Care

I ☐ do / ☐ do not (check one) authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse to administer Diabetes Care to my child while in attendance at Weimar ISD or Weimar ISD related events (such as field trips and athletic events), when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein. **Parent initials** _____

Parent/Guardian Consent to Share Information and Picture

I ☐ do / ☐ do not (check one) authorize Weimar ISD to display a picture of my child and identify that this is a person with diabetes. I understand that school staff that comes into contact with my child will be given (nature of condition / diabetes) information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year. **Parent Initials** _____

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other WISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described herein shall not be provided to a student without the required consent of the parent/guardian, as outlined herein. **Parent initials** _____

Parent/Guardian Release of Claims against District and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless the District for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the administration of Diabetes Care to the student and/or Student's self-administration of the Diabetes Care. This release is to be construed as broadly as possible. It includes a release of claims against the District for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's administration of Diabetes Care to the student, Student's self-administration of Diabetes Care, or the disclosure of the student's Individually Identifiable Health Information, including but not limited to claims that School Staff failed to properly and sufficiently assess my child's knowledge and ability to identify symptoms and self-administer his/her administration of Diabetes Care negligently failed to recognize symptoms requiring the use of Diabetes Care, misconstrued symptoms which it believed necessitated the use of Diabetes Care, administered or failed to administer Diabetes Care, and/or "over disclosed" my child's health information.

Parent's Name _____ **Phone Number** _____

Parent's Signature _____ **Date** _____