



**Bethlehem Catholic High School**

2133 Madison Avenue  
Bethlehem, PA 18017  
Fax: 610-866-4429

***Becahi's Health Room***

610-866-0791 ext. 328  
nurse@becahi.org

**DIABETES MEDICAL MANAGEMENT PLAN**

Student: \_\_\_\_\_ Gr/Teacher: \_\_\_\_\_ DOB/Age: \_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_  
Name Relationship Phone

Emergency Contact #2: \_\_\_\_\_  
Name Relationship Phone

Physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_

**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

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

**Student's self-care blood glucose checking skills: All blood drawing done in Health Room**

Independently checks own blood glucose (must be done in school's Health Room)

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)

**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

**Correction Dose:** \_\_\_\_\_

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

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

Correction dose scale (use instead of calculation 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

**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: \_\_\_\_\_

**ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP**

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

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

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

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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 abilities:

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: \_\_\_\_\_

### 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.

## DIABETES EMERGENCY ACTION PLAN

### HYPOGLYCEMIA: (LOW BLOOD SUGAR)

**MILD**           **MODERATE**           **SEVERE**

___ Hungry ___ Tired/drowsy ___ Shaky/weak ___ Fast heartbeat ___ Clammy ___ Pale skin color ___ Blurred Vision ___ Dizzy/Headache ___ Sweaty/flushed/hot ___ Other _____ ___ Usually has no symptoms	___ Mood/behavior changes ___ Inattentive/spacey ___ Slurred/garbled speech ___ Anxious/Irritable ___ Numbness or tingling around lips ___ Poor coordination ___ Unable to concentrate ___ Personality change ___ Other _____ ___ Usually has no symptoms	___ Confused ___ Unable to follow commands ___ Unconscious ___ Seizure breathing ___ Convulsion ___ Other: _____
---	--	---

<b>Treatment:</b> <input type="checkbox"/> Give _____ grams of carbohydrates of one of the following <input type="checkbox"/> ___ oz. milk <input type="checkbox"/> ___ oz. fruit juice <input type="checkbox"/> ___ grams of glucose gel <input type="checkbox"/> ___ glucose tabs <input type="checkbox"/> other _____ <input type="checkbox"/> Recheck blood glucose in 15 minutes or <input type="checkbox"/> Other _____ <input type="checkbox"/> If blood glucose is less than _____ mg/dL, give another _____ grams of carbohydrates	<input type="checkbox"/> Give _____ grams of carbohydrates of one of the following <input type="checkbox"/> ___ oz. milk <input type="checkbox"/> ___ oz. fruit juice <input type="checkbox"/> ___ grams of glucose gel <input type="checkbox"/> ___ glucose tabs <input type="checkbox"/> other _____ <input type="checkbox"/> Recheck blood glucose in 15 minutes or <input type="checkbox"/> Other _____ <input type="checkbox"/> If blood glucose is less than _____ mg/dL, give another _____ grams of carbohydrates	<input type="checkbox"/> Give Glucagon as prescribed below <input type="checkbox"/> Insulin pump user - disconnect tubing from student <input type="checkbox"/> Suspend insulin pump <input type="checkbox"/> Other _____ _____ _____
--	---	--

**If student is confused/unable to follow commands, unable to swallow, unable to awaken (unconscious) or having a seizure/convulsion give:**

**Glucagon** \_\_\_ 0.5mg or \_\_\_ 1.0mg

**Injection site** \_\_\_ arm \_\_\_ thigh \_\_\_ other \_\_\_\_\_

### HYPERGLYCEMIA: (HIGH BLOOD SUGAR)

**MILD**           **MODERATE**           **SEVERE**

___ Frequent urination ___ Extreme thirst/dry mouth ___ Sweet, fruity breath ___ Tiredness/fatigue ___ Increased hunger ___ Blurred Vision ___ Flushed skin ___ Lack of Concentration ___ Other _____ ___ Usually has no symptoms	___ Mild symptoms and ___ Nausea/vomiting ___ Stomach pain/cramps ___ Dry/itchy skin ___ Unusual weight loss ___ Poor coordination ___ Other _____	___ Mild to moderate symptoms and ___ Labored breathing ___ Weakness ___ Confusion ___ Unconsciousness ___ Other: _____
--	--	--

#### **Treatment for ketones:**

<b>Trace/small:</b> Provide correction/supplemental dose of insulin (see insulin/pump section) <input type="checkbox"/> If blood sugar is: _____ mg/dL <b>and/or</b> if student is sick = <b>check ketones</b> <input type="checkbox"/> Blood glucose $\geq$ _____ mg/dL <b>without ketone</b> recheck blood glucose levels in • 2 hours <input type="checkbox"/> Blood glucose $\geq$ _____ mg/dL <b>with ketones</b> .... <input type="checkbox"/> Allow free bathroom access <input type="checkbox"/> Encourage water and/or sugar-free fluid <input type="checkbox"/> Recheck blood glucose levels in 2 hours <input type="checkbox"/> Recheck ketones in 2 hours <input type="checkbox"/> Other _____	<b>Moderate/Large:</b> <input type="checkbox"/> Same as trace/small ketones and <input type="checkbox"/> Call parents/guardians to arrange to see healthcare provider
---	---

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

