



Kaiser Permanente's School Form

INSTRUCTIONS

Student's Name _____

Medical Record Number _____

Dear Parent(s):

It is again time to **prepare for your child to go back to school**. Please disregard this if it is not applicable to your family situation. In order to assist you with this process, please follow the steps outlined below:

1. Complete **all** areas of the form to include current dosing information. **Incomplete forms will be returned to you.**
2. Send all pages to the Pediatric Diabetes Clinic (at the address below) with written instructions for handling.

*****Please note: We are no longer able to fax school forms.*****

Mail it back to you (please include your full name, address, & telephone #)

Parent will pick up form (date and time you wish to pick up form) allowing for a **2 week turn around time...**

All forms will be reviewed and signed on Friday mornings. Processing time for all school forms will be **2 weeks from the time we receive the form.**

Sincerely,

Brenda Eby-Fink, RN CDE
Vicky Bills, RN
Pediatric Diabetic Clinic
Kaiser Permanente
1600 Eureka Blvd.
Roseville, CA 95661
916-474-2275

Kaiser Permanente Pediatric Diabetes Care Center

Student's Name _____

Medical Record Number _____

DIABETES MEDICAL MANAGEMENT PLAN

The Effective Dates of this Plan are from: _____ to _____

Physical condition Type 1 Diabetes Type 2 Diabetes

CONTACT INFORMATION

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Teacher: _____

Mother / Guardian: _____

Address: _____

Telephone: Home (____) _____^{Street} Work (____) _____^{City} Cell (____) _____^{Zip}

Father / Guardian: _____

Address: _____

Telephone: Home (____) _____^{Street} Work (____) _____^{City} Cell (____) _____^{Zip}

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone: Home (____) _____ Work (____) _____ Cell (____) _____

Student's Doctor / Health Care Provider

Dr. Sobha Kollipara Dr. Frances Hoe Dr. Sudha Reddy

Address: 1600 Eureka Road, Roseville, CA 95661

Telephone: (916) 474-2275

(Please note: before we are able to discuss this student, we are required to have an Authorization for release of Information signed by the parent / guardian)

Kaiser Permanente Pediatric Diabetes Care Center

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DIABETES MEDICAL MANAGEMENT PLAN

BLOOD GLUCOSE MONITORING

Target range for blood glucose is: **100 to 180**

Routine times to check blood glucose at school are: **before meals**

Times to do extra blood glucose checks are (*check all that apply*)

___ before exercise

___ after exercise

___ when student exhibits symptoms of hyperglycemia

___ when student exhibits symptoms of hypoglycemia

___ other (*explain*) _____

FOR THOSE USING INSULIN INJECTIONS

Lunchtime Dose

___ Base dose of insulin to be given is: _____ (*name*) _____ units

___ Flexible dose of insulin to be given is: _____ (*name*) _____ units / _____ grams of carbohydrates

___ Other insulin to be given is: _____ (*name*) _____ units

Insulin Correction (*Sliding Scale*)

Name of Insulin to be given is: _____

_____ units if blood glucose is _____ to _____ mg./dl

_____ units if blood glucose is _____ to _____ mg./dl

_____ units if blood glucose is _____ to _____ mg./dl

_____ units if blood glucose is _____ to _____ mg./dl

_____ units if blood glucose is _____ to _____ mg./dl

Can student perform own blood glucose checks Yes No with supervision

Can student calculate carbohydrates independently Yes No with supervision

Can student determine correct amount of insulin Yes No with supervision

Can student draw correct dose of insulin Yes No with supervision

Can student give own injections Yes No with supervision

Can student carry own supplies Yes No with supervision

Instructions for when food is provided to the class (e.g., class parties): _____

DIABETES MEDICAL MANAGEMENT PLAN

STUDENT WITH INSULIN PUMPS

Type of Insulin in pump: _____
 Type of Infusion set: _____ Inserting Device Used: _____
 Insulin / carbohydrate ratio: _____ Correction factor: _____

Basal rates: 12 am - _____ units / hr
 _____ - _____ units / hr
 _____ - _____ units / hr

Pump Ability / Skills

Needs Assistance

- | | | |
|--|------------------------------|-----------------------------|
| Bolus correction amount for carbohydrates | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and administer corrective bolus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set temporary basal rate | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Disconnect / reconnect pump at infusion site | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prepare reservoir and tubing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insert infusion set | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Troubleshoot alarms and malfunctions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

EXERCISE AND SPORTS

A fast acting carbohydrate such as **juice or regular soda** should be available at the site of exercise or sports.

Student should not exercise if blood glucose level is below **80 mg / dl** or above **400 mg / dl**.

Supplies to be Kept at School (*Provided by parent or guardian*)

- _____ Blood glucose meter, blood glucose test strips, batteries for meter
- _____ Lancet device, lancets, gloves etc.
- _____ Fast acting source of glucose
- _____ Insulin vials and syringes
- _____ Carbohydrate containing snack
- _____ Insulin pump and supplies
- _____ Insulin pen, pen needles
- _____ Urine / blood ketone strips
- _____ Glucagon emergency kit

DIABETES MEDICAL MANAGEMENT PLAN

HYPOGLYCEMIA (LOW BLOOD SUGAR)

Usual symptoms of hypoglycemia: Shaky, sweating and / or pale.

Treatment of hypoglycemia: **15 grams of a fast acting carbohydrate and recheck in 15 minutes, if still less than 80 mg / dl then repeat 15 grams and recheck in 15 minutes.**

_____ (*Dosage*) Glucagon should be given intramuscularly (IM) if the student is unconscious, having a seizure (convulsion), or unable to swallow. Site for Glucagon injection may be arm, thigh, or buttock.

If glucagon is required, administer it simultaneously while calling 911 and the parent / guardians.

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

Usual symptoms of hyperglycemia: **Tired, thirsty, increased urination**

Treatment of hyperglycemia: **Hydrate with water and give insulin**

*******Call parent if blood sugar above _____ mg / dl**

PHYSICIAN'S AUTHORIZATION FOR DABETES MEDICAL MANAGEMENT PLAN:

My signature below provides authorization for this Diabetes Medical Management Plan. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by a school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization.

Physician's Name: _____

Physician's Signature: _____ Date: _____

Address: 1600 Eureka Road City / Zip: Roseville, CA 95661

Physician's Telephone: (916) 474-2275 Physician's Fax: (916) 474-2271