_____ County School District Health Services

DIABETES MEDICAL MANAGEMENT PLAN

STUDENT/CONTACT INFORMATION			
Student Name:	DOB:	Diabetes Type:	Date Diagnosed:
School Year: 2023-2024	Effective Date:	School:	Grade:
Parent/Guardian #1:	Primary #:	Secondary #:	Email:
Parent/Guardian #2:	Primary #:	Secondary #:	Email:
Other Emergency Contact:	Primary #:	Secondary #:	Relationship:
Diabetes Healthcare Provider:		Phone #:	Fax #:

DIABETES SELF-CARE ASSESSMENT

Student can carry DM supplies: ☐ **Yes** ☐ **No**

Task	**N/A**	**Needs Assistance**	**Needs Supervision**	**Independent (requires no help/supervision for routine care)**
Performs and Interprets Blood Glucose Checks	☐	☐	☐	☐
Calculates Carbohydrate Grams	☐	☐	☐	☐
Determines Correction Dose of Insulin for High Blood Glucose	☐	☐	☐	☐
Determines Insulin Dose for Carbohydrate Intake	☐	☐	☐	☐
Administers Insulin by pump or injection	☐	☐	☐	☐
Troubleshoots alarms and malfunctions if using insulin pump	☐	☐	☐	☐
Disconnects/reconnects pump site or pod if needed	☐	☐	☐	☐
Programs pump basal rates/sets temporary rates if needed	☐	☐	☐	☐
Changes insulin pump infusion site/pod if needed	☐	☐	☐	☐
Responds to CGMS alarms	☐	☐	☐	☐

BLOOD GLUCOSE MONITORING AT SCHOOL

Target BG range: ___ to ___	***Notify parent if BG is below _ mg/dL or over _ mg/dL***

Check blood glucose level:

☐ Before Breakfast *(if child did not eat or receive insulin at home).* ☐ Before Lunch

☐ Before Mid-AM Snack ☐ Before Mid-PM Snack

☐ Before Physical Activity ☐ After Physical Activity ☐ Before Dismissal

☐ As Needed for Signs/Symptoms of High/Low BG/Illness ☐ Other BG Check:_____

CONTINUOUS GLUCOSE MONITOR SENSOR (CGMS)

Continuous Glucose Monitor Sensor (CGMS): ☐ N/A ☐ Yes, Brand/Model:_____

☐ CGMS works with pump to: ☐ Suspend basal insulin due to predicted low BG

☐ Increase/decrease/suspend basal &/or bolus due to predicted high/low BG.

Low Glucose Alert Setting: ____ mg/dL	☐ CGMS is remotely monitored by parent.
High Glucose Alert Setting: ____ mg/dL	School clinic staff to assist student with alarms as needed

Sensor readings can be used for calculation of insulin unless there are 2 up or down trend arrows (for Dexcom), 1 up or down arrows (for Libre) or student presents with signs/symptoms of high/low blood glucose regardless of CGMS value.
***Confirm CGM sensor glucose with BG check if this occurs*.**

Notify parent if CGMS site is painful, draining/bleeding, inflamed, or irritated.

Student Name _____

LOW BLOOD GLUCOSE (HYPOGLYCEMIA) MANAGEMENT

Management of Low Blood Glucose below ____ mg/dL (or below 70 mg/dL if not specified)

Student's Usual Signs and Symptoms (Guardian to fill out all that apply):

☐ Shakiness	☐ Sweating	☐ Paleness	☐ Rapid Heartbeat	☐ Numbness/ Tingling	☐ Irritability/ Mood Change	☐ Fatigue
☐ Headache	☐ Inattention/ Confusion	☐ Slurred Speech	☐ Poor Concentration	☐ Seizure	☐ Loss of Consciousness	☐ Other:

Low Blood Glucose Treatment:

If student is awake and able to swallow/control airway:

1. Give 15 grams of fast-acting carbohydrates such as:
   4 oz fruit juice 3-4 glucose tablets 5 oz. regular soda 8 oz. low fat milk 15 gm tube glucose/cake gel
2. Re-check blood glucose every 15 minutes and re-treat until blood glucose is over ____ mg/dL.
3. Treat with 15 grams of solid carbs or follow with scheduled meal once blood sugar is over ____ mg/dL.
4. Delay exercise if blood glucose is below ____ mg/dL (or 100 mg/dL if not specified).

If student is unresponsive, having a seizure, or unable to control airway, **call 911 immediately and notify parents**.

Position student on their side if possible & have trained personnel administer emergency medication listed below:

Glucagon/Glucagen IM ☐ 0.5mg ☐ 1.0mg
Gvoke subq ☐ 0.5mg ☐ 1.0mg
Baqsimi intranasal ☐ 3 mg ☐ Give 15gm tube glucose/cake gel
Zegalogue subq ☐ 0.6mg

If on a pump, place pump in suspend/stop mode or disconnect/cut tubing. Send pump with EMS.
Contact diabetes healthcare provider if unable to reach parents within 20 minutes if severe hypoglycemia or low BG treatment is ineffective.

Predictive low blood sugar with CGMS ☐ N/A ☐ **F**ollow Instructions below

If blood sugar is below _____ with 2 down arrows on a Dexcom CGMS or 1 down arrow on a Libre CGMS, give a snack of _____ grams of carbohydrates to avoid low blood sugar.

***If this occurs at mealtime, do not give an extra snack just feed the student the meal.** Refer to "**Diabetes Medication**" section for insulin dosing orders.*

HIGH BLOOD GLUCOSE (HYPERGLYCEMIA) MANAGEMENT

Management of High Blood Glucose over ___ mg/dL (or above 300 if not specified)

Student's Usual Signs and Symptoms (Guardian to fill out all that apply):

☐ Increased Thirst	☐ Increased Urination	☐ Headache	☐ Fatigue/ Drowsiness	☐ Dry Skin	☐ Weakness/ Muscle Aches	☐ Blurred Vision
☐Nausea/ Vomiting	☐Abdominal Pain	☐ Dizziness	☐Fruity Breath Odor	☐Altered Breathing	☐ Other:	☐ Other:

High Blood Glucose Treatment:

1. See correction insulin instructions under "Diabetes Medications at School" below.
2. Give 8 oz. of water or other sugar-free liquids/water if not vomiting. Allow frequent bathroom privileges.
3. Check ketones if blood glucose over ____ mg/dL (or over 300 mg/dL if not specified) **AND/OR** complaints of illness, stomachache or nausea/vomiting.
   Negative-Small Ketones (blood 0-1mmol/L) **without symptoms**:
   Notify parent for positive ketones. Student may return to class with frequent bathroom privileges.
   Moderate-Large Ketones (blood over 1mmol/L):
   Notify parent. Stay with student and repeat ketone check with each void or in one hour.
4. Parent to pick up student if experiencing symptoms of illness (as defined above).
5. **Parent to pick up student if moderate-large ketones persist after one hour regardless of symptoms.**
6. *Advise parent to call diabetes care provider for further instructions if picked up due to ketones &/or symptoms*
7. **If you are unable to reach parent to pick up student, call EMS.**
8. Delay exercise if blood glucose is over ___ mg/dL (over 300 mg/dL if not specified) ☐ **AND,** ☐ **OR** mod-large ketones
9. Re-check blood glucose in __ minutes if previous blood sugar was over _____ mg/dL.

Student Name _____

DIABETES MEDICATION AT SCHOOL

Insulin Delivery Method: ☐ n/a ☐ Vial ☐ Pen ☐ Smartpen ☐ Pump

Rapid-Acting Insulin Brand: ☐ Humalog (Lispro) ☐ NovoLog (Aspart) ☐Lyumjev ☐ Admelog ☐ Fiasp ☐ Apidra
☒ May substitute brand if needed

Fixed Rapid-Acting Insulin Dose to be given with meals: ☐ n/a ☐ ___ units ☐ Add fixed dose to Correction Scale ☐ **Mealtime Insulin Sliding Scale** (Only for mealtimes)	☐ **Correction Only Formula (Instead of Scale) give before meals unless instructed differently in meals/snacks section.** **Times:** ☐ Breakfast ☐ Lunch ☐ Other: _____
If blood glucose: *Insulin Dose*	Target Blood Glucose (BG) = _____mg/dL
_____to _____ give _____ units	Correction (Sensitivity) Factor = _____ mg/dL
_____ to _____ give _____ units	(Blood Glucose-Target BG) ÷ Correction Factor = # of units to correct high BG
_____ to _____ give _____ units	i.e. (Current BG-_____) ÷ _____= _#_ units
_____ to _____ give _____ units	☐Give correction dose if over ___ hours since last dose. (For injections)
_____ to _____ give _____ units	☐Add correction dose to Flexible Carb Coverage per "Meals/Snacks" below
_____ to _____ give _____ units	☐Round to nearest ☐ 0.5 unit ☐ 1 unit (For injections)
_____ to _____ give _____ units	☐Always round fraction down (For injections)
_____ to "HI" give _____ units	☐ Insulin Pump or ☐ InPen will calculate dose if using. Give correction of carb coverage dose as needed per pump or Smartpen recommendations.

Other diabetes medication(s) to be taken at school: ☐ n/a (Type/Dose/Time)

☐ Give insulin for food once blood sugar is over _____ mg/dL following treatment for a low.

Parent/Guardian authorization to adjust insulin dose: ☐ n/a
☐ May increase or decrease insulin dose within the following range: +/- ___ units of insulin.
☐ May extend bolus: ___ -___ % delivered now, and extended portion given over ___ - ___ minute duration.

MEALS/SNACKS

Meal/Snack	Time	Carbohydrate Target ☐ As desired	Flexible Carb Coverage (Insulin: Carb Ratio +/- Correction)	
☐ Breakfast (if child did not eat or receive insulin at home)	_____	_____ grams	1 unit: _____ grams	☐ Add Correction
☐ Mid AM Snack	_____	_____ grams	1 unit: _____ grams	☐ Add Correction
☐ Lunch	_____	_____ grams	1 unit: _____ grams	☐ Add Correction
☐ Mid PM Snack	_____	_____ grams	1 unit: _____ grams	☐ Add Correction
☐ Before/After Physical Activity	_____	_____ grams	1 unit: _____ grams	☐ Add Correction
☐ Other: _____	_____	_____ grams	1 unit: _____ grams	☐ Add Correction

☐ Meal/snack should be timed at least ___ hours after last meal/snack if BG to be checked, unless food is given to avoid a low BG based on CGM readings.	☐ Pre-meal insulin can be given after meal based on pre-meal BG if student's carbohydrate intake is unpredictable.	☐ Pre-meal insulin can be given after meal if BG is below 80.

☐ Following Gluten-Free Diet.
Further dietary meal plan instructions may need documentation based on county guidelines.

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ADDITIONAL CONSIDERATIONS FOR STUDENT WITH AN INSULIN PUMP

☐ Any glucose over ____, check ketones. Follow high blood glucose instructions. If moderate to large ketones and/or symptoms of hyperglycemia, give correction dose by injection and have trained person change infusion set. If ketones negative or trace, please give correction dose with pump, retest blood glucose in 1 hour to verify pump is working and blood glucose level is decreasing. Notify parent if assistance needed and/or if ketones are moderate to large.

☐ Inspect pump site, tubing/pod in event of alarms, high blood glucose, or student complains of pain at infusion site. Contact parent if pump site dislodged or leaking.

☐ If student experiences severe hypoglycemia, suspend/remove pump or cut tubing. Send non-disposables with EMS to hospital.

ADDITIONAL TIMES TO NOTIFY PARENT/GUARDIAN/PROVIDER

☐ Student refusing medication. ☐ Correction dose given less than 1 hour before dismissal.

☐ Student unavoidably detained at school ☐ Unusual reaction to any diabetes medication.

☐ School Activity that would impact timing or delivery of snack/meal or insulin ☐ Other: _____

DISASTER PLAN

In case student's normal diabetes management routine and support is disrupted by unexpected emergency:

Re-unite student as soon as safely possible with diabetes supplies/emergency kit and trained caregiver/parent.

Keep student as well-hydrated as possible and keep rapid-acting carbohydrate with student.

☐ Student able to self-manage during disaster conditions unless incapacitated.

Contact parent/ diabetes team for additional instructions.

Keep disaster bags in all assigned classrooms where lockdowns occur. Parents to provide.

SUPPLIES TO BE FURNISHED BY PARENT TO SCHOOL

☐ BG strips, meter, lancets, lancing device	☐ Snacks: carb and carb-free	☐ Insulin pen/cartridges, pen needles	☐ Glucagon/ Glucagen/ Gvoke/Baqsimi	☐ Pump Infusion Sets/Pods	☐Spare batteries/ Charging cord for meter/pump/CGM
☐ Ketone strips &/or blood ketone meter	☐ Insulin vial/ syringe	☐ Juice, glucose tabs/gel/ regular soda	☐ Other diabetes prescription meds	☐ Pump reservoirs/ cartridges	☐ Other: _____

SIGNATURES/ PARENTAL CONSENT

This Diabetes Medical Management Plan has been approved by:

Provider stamp

Diabetes Healthcare Provider Signature: _____

Date: _____

I (parent/guardian) understand that all treatments and procedures may be performed by the student and/or trained unlicensed assistive personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed this medical management plan and agree with the indicated instructions. This form will assist the school health personnel in developing a nursing care plan.

I 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 authorized school personnel to contact my child's diabetes healthcare provider when necessary.

Parent Signature: _____ Date: _____

School RN: _____ Date: _____