Volusia County Schools

Diabetes Medical Management Plan

STUDENT/CONTACT INFORMATION

Student Name:	DOB:	Diabetes Type:	Date Diagnosed:

School Year:	Effective Date:	School:	Grade:

Parent/Guardian 1:	Primary Phone Number:	Secondary Phone Number:	Email Address:
Parent/Guardian 2:	Primary Phone Number:	Secondary Phone Number:	Email Address:
Other Emergency Contact:	Primary Phone Number:	Secondary Phone Number:	Relationship:
Diabetes Healthcare Provider:		Phone Number:	Fax Number:

DIABETES SELF-CARE ASSESSMENT

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

Task	n/a	Needs Assistance	Needs Supervision	Independent (requires no supervision)
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 CGM alarms	☐	☐	☐	☐

BLOOD GLUCOSE MONITORING AT SCHOOL

Target BG range to: _____ 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 dismissal
☐ Before physical activity	☐ After physical activity	
☐ As needed for signs/symptoms of high / low BG / illness	☐ Other BG check: _____	

CONTINUOUS GLUCOSE MONITOR (CGM)

Continuous Glucose Monitor (CGM): ☐ **n/a** ☐ **Yes, Brand/Model: _____**

☐ CGM works with pump to:

☐ Suspend basal insulin due to predicted low BG	☐ Increase/decrease/suspend basal and/or bolus due to predicted high/low BG
Low glucose alert setting: _____ mg/dL	☐ CGM 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 to deliver insulin unless there are two up or down trend arrows <u>or</u> student presents with signs/symptoms of high/low blood glucose regardless of CGM value.
Confirm CGM sensor glucose with BG check if this occurs.
Notify parent if CGM 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 (parent/Guardian to fill out all that apply):

☐ Shakiness	☐ Sweating	☐ Paleness	☐ Rapid heartbeat	☐ Numbness / Tingling	☐ Irritability / Mood change	☐ Fatigue
☐ Headache	☐ Inattention / Confusion	☐ Slurred speech	☐ Poor coordination	☐ Seizure	☐ Loss of consciousness	☐ Other:

Low Blood Glucose Treatment:

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

1. Give **15** grams 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 and have trained personnel administer emergency medication listed below:
- **Glucagon/Glucagen** IM: ☐ 0.5 mg ☐ 1.0 mg
- **Gvoke** subq: ☐ 0.5 mg ☐ 1.0 mg
- **Baqsimi** intranasal: ☐ 1.0 mg
- ☐ Give 15 gm tube glucose/cake gel

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.

HIGH BLOOD GLUCOSE (HYPERGLYCEMIA) MANAGEMENT

Management of high blood glucose over _____ mg/dL (or above 300 mg/dL if not specified)

Student's Usual Signs and Symptoms (parent/guardian to fill out all 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 0-1 mmol/L) **without symptoms**:
   Notify parent for positive ketones. Student may return to class with frequent bathroom privileges.
   Moderate-Large ketones (blood over 1 mmol/L):
   Notify parent. Stay with student and repeat ketone check with each void or in one hour.
4. Parent/Guardian to pick up student if experiencing symptoms of illness (as defined above).
5. **Parent/Guardian 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 and/or symptoms.*
7. **If you are unable to reach parent/guardian to pick up student, call EMS.**
8. Delay exercise if blood glucose is over _____ mg/dL (or over 300 mg/dL if not specified) **or** mod-large ketones.
9. Re-check blood glucose in _____ minutes if previous blood sugar was over _____ mg/dL.

ADDITIONAL CONSIDERATION FOR STUDENT WITH AN INSULIN PUMP

☐ Any glucose over **250 mg/dL**, check ketones. Follow high blood glucose instructions. Check ketones if needed/or symptoms of hyperglycemia, give correction dose by **injection** and have student change infusion set. If ketones negative or trace, please give correction dose with pump, retest blood glucose in one 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.

Student Name: _____

ADDITIONAL TIMES TO NOTIFY PARENT/GUARDIAN/PROVIDER

☐ Student refusing medication	☐ Correction dose given less than one 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: _____

DIABETES MEDICATION AT SCHOOL

Insulin Delivery Method: n/a | Pen | Smartpen | Pump

Rapid-Acting Insulin Brand: Humalog | NovoLog | Apidra | Admelog | Fiasp | 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)**

If blood glucose:		*Insulin Dose:*	
_____	to _____	give _____	units
_____	to _____	give _____	units
_____	to _____	give _____	units
_____	to _____	give _____	units
_____	to _____	give _____	units
_____	to _____	give _____	units
_____	to "HI"	give _____	units

☐ **Correction only formula (instead of scale) give before meals unless instructed differently in meals/snacks section**

Times: ☐ Breakfast ☐ Lunch ☐ Other: _____

Target Blood Glucose (BG): mg/dL

Correction (Sensitivity) Factor: mg/dL

(Blood Glucose – Target BG) ÷ Correction Factor = # units to correct high BG
i.e., (Current BG – _____) ÷ _____ = _____ units

☐ Give correction dose if over _____ hours since last dose and/or carbohydrate intake.

☐ Add correction dose to Flexible Carb Coverage per "Meals/Snacks" below.

☐ Round to nearest ☐ 0.5 unit ☐ 1 unit

☐ Always round fraction down

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 with 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.

☐ 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.

DISASTER PLAN

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

Student Name: _____

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 core for meter / pump / CGM	☐ Ketone strips and/or blood ketone meter	☐ Insulin vial / syringe	☐ Juice, glucose tabs / gel or regular soda	☐ Other prescribed diabetes 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: _____