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 MONITORING AT SCHOOL

Blood Glucose Range: to	**Ketones:** ☐ **Urine** ☐ **Blood** ☐ **n/a**	**Continuous Glucose Monitoring:** ☐ **n/a**
☐ Check Before Breakfast ☐ Check Before Mid-AM Snack ☐ Check Before Lunch	☐ Check ketones if blood glucose over 300 mg/dL.	Brand: High Glucose Alert Setting: ________ mg/dL Low Glucose Alert Setting: mg/dL
☐ Check Before Afternoon Snack ☐ Check Before Physical Activity ☐ Check After Physical Activity	☐ Check ketones for complaints of abdominal pain, nausea / vomiting. ☐ Other times to check ketones: ________________________________	**Sensor readings can be used to deliver insulin unless there are <u>2 up or down trend arrows</u>. Confirm CGM sensor glucose with BG check before corrective action when <u>2 up or down trend arrows</u> are present.**
☐ Check Before Dismissal ☐ Check if S/S of High/Low Blood Glucose	*Note: Normal blood ketones below 0.6 mmol/L*	* Only give a correction dose if over 2.5 hours since last dose and/orcarbohydrate intake. * Check BG if signs/symptoms of high/low glucose regardless of CGM value.
☐ Other Blood Glucose Check ☐ **Notify Parent if BG over <u>400</u> mg/dL***	☐ **Notify parent if ketones <u>positive</u>* (to pick up child if urine ketones mod-lg or blood ketones > 1 mmol/L.**	**Notify parent if CGM site painful, draining/bleeding, inflamed, irritated.***

Delay exercise if: Blood glucose is below **<u>70</u>**, over **<u>400</u>**, ketones moderate, or <u>large</u>.

** Diabetes Healthcare Provider will be contacted if unable to reach parent within 30 minutes.*

DIABETES MEDICATION AT SCHOOL

Insulin Delivery Method: ☐ n/a ☐ Pen ☐ Syringe/Vial ☐ Pump – Brand/Model:

Rapid-Acting Insulin Brand: ☐ Humalog ☐ NovoLog ☐ Apidra ☐ Admelog ☐ May substitute brand if needed

Fixed Rapid-Acting Insulin Dose to be given with meals: ☐ n/a ☐ _____ units ☐ Add fixed dose to Correction Scale below

☐ Correction Scale Times:		☐ Correction Only Formula (Instead of Scale) Times:
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 = # 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 and/or carbohydrate intake.
________ to ________	give ________ units	☐ Add correction dose to Flexible Carb Coverage per "Meals/Snacks" on page 2.
________ to ________	give ________ units	☐ Round to nearest ☐ 0.5 unit ☐ 1 unit
to "HI"	give units	☐ Always round fraction down.

Parent can adjust insulin dose as follows: ☐ n/a ☐ (Providers, please be specific):

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

Student Name: ________________________

MEALS/SNACKS

Meal/Snack	Time	Carbohydrate Target ☐ As Desired	Flexible Carb Coverage (Insulin : Carb Ratio +/- Correction)	
☐ Breakfast		grams	☐ 1 unit: grams	☐ Add Correction (pg. 1)
☐ Mid-AM Snack		grams	☐ 1 unit: grams	☐ Add Correction (pg. 1)
☐ Lunch		grams	☐ 1 unit: grams	☐ Add Correction (pg. 1)
☐ Mid-PM Snack		grams	☐ 1 unit: grams	☐ Add Correction (pg. 1)
☐ Before/After Physical Activity		grams	☐ 1 unit: grams	☐ Add Correction (pg. 1)
☐ Other:		grams	☐ 1 unit: grams	☐ Add Correction (pg. 1)

☐ 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.

HIGH BLOOD GLUCOSE (HYPERGLYCEMIA) MANAGEMENT

Student's Usual Signs and Symptoms (Mark all that apply):

High Blood Glucose: (Over 240 mg/dL)	☐ Increased thirst and/or urination	☐ Hunger	☐ Headache	☐ Fatigue / Drowsiness	☐ Dry Skin	☐ Weakness / Muscle Aches	☐ Blurred Vision
Very High Blood Glucose: (Over 400 mg/dL)	☐ Nausea / Vomiting / Abdominal Pain	☐ Dizziness	☐ Extreme Thirst	☐ Fruity Breath Odor	☐ Altered Breathing	☐ Other:	

High Blood Glucose Treatment:

☐ See correction insulin instructions under "Diabetes Medications at School" on pg. 1.

☐ Check "Ketones" (see *Diabetes Monitoring*).

☐ If urine ketones are negative to trace (blood 0-1 mmol/L) without symptoms, give insulin correction dose (see *Diabetes Medications*), give 8-10 oz. sugar-free fluid/hour, and send back to class with frequent bathroom privileges.

☐ Re-check blood glucose in 60 minutes if previous blood sugar was over **400** mg/dL.

☐ Delay next meal/snack until blood glucose is below **250** mg/dL if previous blood sugar was over **400** mg/dL.

☐ If urine ketones are moderate to large (blood over 1 mmol/L) notify parent and call diabetes healthcare provider for insulin dose instructions. Give sugar-free liquids/water if not vomiting and stay with student.

☐ Call parent if high blood glucose accompanied by symptoms of illness.
Child to go home for moderate to large ketones (blood ketones over 1mmol/L or high blood glucose with symptoms of illness.

LOW BLOOD GLUCOSE (HYPOGLYCEMIA) MANAGEMENT

Low Blood Glucose = Blood Glucose Below _____ mg/dL ☐ Not Applicable

Student's Usual Signs and Symptoms (Mark 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, give **15** grams fast-acting carbohydrate- e.g.*

4 oz. fruit juice **3-4** glucose tablets **5** oz. regular soda **8** oz. low fat milk **15** gm tube glucose gel

Re-check blood glucose every 15 minutes and re-treat until blood glucose is over **70**.

Treat with 15 grams of solid carbs once blood sugar is over _____ mg/dL. ** Once blood sugar is over _____ mg/dL give insulin, if needed, based on recheck BG per correction scale on page 1 or for food based on carb ratio on page 2.

If student has severe hypoglycemia (is unresponsive/having seizure/unable to control airway): Call 911 or send another to do so.

☐ Trained personnel to give Glucagon/Glucagen subq/IM – ☐ 1/2 mg ☐ 1 mg ☐ Give 15 gm tube glucose gel

☐ Contact parent/guardian if glucagon/gel given for severe hypoglycemia or if low blood glucose treatment is ineffective. Call diabetes healthcare provider if unable to reach parent within 20 minutes.

ADDITIONAL CONSIDERATION FOR STUDENT WITH AN INSULIN PUMP

☐ If blood glucose over _____ mg/dL _____ times in a row or any glucose over _____ check ketones. Follow high blood glucose instructions **BUT** give correction dose with syringe or pen and have student change infusion set. Notify parent if assistance needed.

☐ 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.
- ☐ Unusual reaction to any diabetes medication.
- ☐ Correction dose given less than one hour before dismissal.
- ☐ Student unavoidably detained at school.
- ☐ Other:

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	☐ Pump Infusion Sets / Pods	☐ Spare batteries for meter / pump / CGM
☐ Ketone strips +/- meter	☐ Juice, glucose tabs / gel or regular soda	☐ Insulin vial / syringe	☐ Other prescribed diabetes med	☐ Pump reservoirs / cartridges	☐ Other

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.

- ☐ Use correction only scale every 3 hours (if at least 3 hours since last insulin/carb intake).
  Switch to rapid acting insulin injections if pump/site fails and unable to restart.
- ☐ Use insulin : carb ratio + correction formula every 3+ hours.
- ☐ Student able to self-manage during disaster conditions unless incapacitated.
  Contact parent/diabetes team for additional instructions.

DIABETES SELF-CARE ASSESSMENT

Task	n/a	Needs Assistance	Needs Supervision	Independent (requires no help/supervision for routine care, can carry meds/supplies)
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 if needed	☐	☐	☐	☐
Programs pump basal rates/sets temporary rates if needed	☐	☐	☐	☐
Changes insulin pump infusion site if needed	☐	☐	☐	☐
Responds to CGM alarms	☐	☐	☐	☐

SIGNATURES/PARENTAL CONSENT

This Diabetes Medical Management Plan has been approved by:

OFFICE STAMP HERE

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: __________

School LPN: ____________________ Date: __________