

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: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Task	n/a	Needs Assistance	Needs Supervision	Independent (requires no supervision)
Performs and interprets blood glucose checks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calculates carbohydrate grams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determines correction dose of insulin for high blood glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determines insulin dose for carbohydrate intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administers insulin by pump or injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Troubleshoots alarms and malfunctions if using insulin pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disconnects/Reconnects pump site or pod if needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Programs pump basal rates/sets temporary rates if needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes insulin pump infusion site/pod if needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responds to CGM alarms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:	
<input type="checkbox"/> Before breakfast (if child did not eat or receive insulin at home)	<input type="checkbox"/> Before lunch
<input type="checkbox"/> Before mid-AM snack	<input type="checkbox"/> Before mid-PM snack <input type="checkbox"/> Before dismissal
<input type="checkbox"/> Before physical activity	<input type="checkbox"/> After physical activity
<input type="checkbox"/> As needed for signs/symptoms of high / low BG / illness	<input type="checkbox"/> Other BG check: _____

CONTINUOUS GLUCOSE MONITOR (CGM)	
Continuous Glucose Monitor (CGM): <input type="checkbox"/> n/a <input type="checkbox"/> Yes, Brand/Model: _____	
<input type="checkbox"/> CGM works with pump to:	
<input type="checkbox"/> Suspend basal insulin due to predicted low BG	<input type="checkbox"/> Increase/decrease/suspend basal and/or bolus due to predicted high/low BG
Low glucose alert setting: _____ mg/dL	<input type="checkbox"/> 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 or 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.	

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):

<input type="checkbox"/> Shakiness	<input type="checkbox"/> Sweating	<input type="checkbox"/> Paleness	<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> Numbness / Tingling	<input type="checkbox"/> Irritability / Mood change	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Headache	<input type="checkbox"/> Inattention / Confusion	<input type="checkbox"/> Slurred speech	<input type="checkbox"/> Poor coordination	<input type="checkbox"/> Seizure	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> 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):

<input type="checkbox"/> Increased thirst	<input type="checkbox"/> Increased urination	<input type="checkbox"/> Headache	<input type="checkbox"/> Fatigue / Drowsiness	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Weakness / Muscle aches	<input type="checkbox"/> Blurred vision
<input type="checkbox"/> Nausea / Vomiting	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fruity breath / Odor	<input type="checkbox"/> Altered breathing	<input type="checkbox"/> Other:	<input type="checkbox"/> 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.

ADDITIONAL TIMES TO NOTIFY PARENT/GUARDIAN/PROVIDER

<input type="checkbox"/> Student refusing medication	<input type="checkbox"/> Correction dose given less than one hour before dismissal
<input type="checkbox"/> Student unavoidably detained at school	<input type="checkbox"/> Unusual reaction to any diabetes medication
<input type="checkbox"/> School activity that would impact timing or delivery of snack/meal or insulin	<input type="checkbox"/> 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

<input type="checkbox"/> Mealtime insulin sliding scale (only for mealtimes)	<input type="checkbox"/> Correction only formula (instead of scale) give before meals unless instructed differently in meals/snacks section
	Times: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Other: _____
<i>If blood glucose:</i>	<i>Insulin Dose:</i>
_____ to _____	give _____ units
_____ to _____	give _____ units
_____ to _____	give _____ units
_____ to _____	give _____ units
_____ to _____	give _____ units
_____ to _____	give _____ units
_____ to "HI"	give _____ units

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		Flexible Carb Coverage (Insulin : Carb Ratio +/- Correction)		
		<input type="checkbox"/> As Desired	grams	<input type="checkbox"/> 1 unit:	grams	<input type="checkbox"/> Add correction
<input type="checkbox"/> Breakfast (if child did not eat or receive insulin at home)			grams	<input type="checkbox"/> 1 unit:	grams	<input type="checkbox"/> Add correction
<input type="checkbox"/> Mid-AM snack			grams	<input type="checkbox"/> 1 unit:	grams	<input type="checkbox"/> Add correction
<input type="checkbox"/> Lunch			grams	<input type="checkbox"/> 1 unit:	grams	<input type="checkbox"/> Add correction
<input type="checkbox"/> Mid-PM Snack			grams	<input type="checkbox"/> 1 unit:	grams	<input type="checkbox"/> Add correction
<input type="checkbox"/> Before/After physical activity			grams	<input type="checkbox"/> 1 unit:	grams	<input type="checkbox"/> Add correction
<input type="checkbox"/> Other:			grams	<input type="checkbox"/> 1 unit:	grams	<input type="checkbox"/> Add correction
<input type="checkbox"/> Meal/snack should be timed at least _____ hours after last meal/snack if BG to be checked.		<input type="checkbox"/> Pre-meal insulin can be given after meal based on pre-meal BG if student's carbohydrate intake is unpredictable.		<input type="checkbox"/> 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

<input type="checkbox"/> BG strips, meter, lancets, lancing device	<input type="checkbox"/> Snacks: Carb and carb-free	<input type="checkbox"/> Insulin pen / cartridges, pen needles	<input type="checkbox"/> Glucagon / Glucagen / Gvoke / Baqsimi	<input type="checkbox"/> Pump Infusion Sets / Pods
<input type="checkbox"/> Spare batteries / Charging core for meter / pump / CGM	<input type="checkbox"/> Ketone strips and/or blood ketone meter	<input type="checkbox"/> Insulin vial / syringe	<input type="checkbox"/> Juice, glucose tabs / gel or regular soda	<input type="checkbox"/> Other prescribed diabetes meds
<input type="checkbox"/> Pump reservoirs / cartridges	<input type="checkbox"/> 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: _____