SHARYLAND ISD HEALTH SERVICES

American Diabetes Association®

Connected for Life

Safe at School®

Diabetes Medical Management Plan

Add student photo here

SCHOOL YEAR: 20_____/20_____

STUDENT LAST NAME: FIRST NAME: DOB:

_____ _____ ____/____/____

TABLE OF CONTENTS

PARENTS/GUARDIANS: Please complete pages 1 and 2 of this form and approve the final plan on page 6.

1. DEMOGRAPHIC INFORMATION—PARENT/GUARDIAN TO COMPLETE

Diabetes Type: _____ Student's Cell #: _____ Date Diagnosed: Month: _____ Year: _____

Grade: _____ School Name: _____ School Phone #: _____ School Fax #: _____

Teacher (If elem.) _____ School Point of Contact: _____ Contact Phone #/Extension: _____ Ext: _____

STUDENT'S SCHEDULE Arrival Time: _____ Dismissal Time: _____

Travels to school by (check all that apply):	**Meal times**:	**Physical activity**:	**Travels to**:
□ Foot/bicycle □ Car □ Bus □ Attends before school or after school program	□ Breakfast □ AM Snack □ Lunch □ PM Snack □ Pre-dismissal Snack □ After school care	□ Gym/PE □ Recess □ Sports Additional information: _____ _____	□ Home □ After school Program Via: □ Foot/bicycle □ Car □ Student driver □ Bus

Parent/Guardian #1 (contact first) _____ Relationship _____

Cell #: _____ Home #: _____ Work #: _____

E-mail Address: _____

Indicate preferred contact methods: _____

Parent/Guardian #2 _____ Relationship _____

Cell #: _____ Home #: _____ Work #: _____

E-mail Address: _____

Indicate preferred contact methods: _____

TX Licensed Physician's Name: _____ Contact # _____

Fax # _____ Address, City, Zip code: _____

Email Address (non-essential communication): _____ Other: _____

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2. NECESSARY SUPPLIES / DISASTER PLANNING / EXTENDED FIELD TRIPS

1. A 3-day minimum of the following Diabetes Management Supplies should be provided by the parent/guardian and accessible for the care of the student at all times.

- Insulin
- Syringe/Pen Needles
- Ketone Strips
- Treatment for lows and snacks
- Glucagon
- Antiseptic Wipes
- Blood Glucose (BG) Meter with (test strips, lancets, extra battery) – required for all Continuous Glucose Monitor (CGM) users
- Pump Supplies (Infusion Set, Cartridge, extra Battery/Charging Cord) if applicable
- Additional supplies: _____

2. View Disaster/Emergency Planning details – refer to Safe at School Guide
3. Please review expiration dates and quantities monthly and replace items prior to expiration dates
4. In the event of a disaster or extended field trip, a school nurse or other designated personnel will take student's diabetes supplies and medications to student's location.

3. SELF-MANAGEMENT SKILLS (DEFINITIONS BELOW) — HEALTHCARE PROVIDER TO COMPLETE

		Full Support	Supervision	Self-Care
Glucose Monitoring:	Meter…… □ (Requires Calibration)	□	□	□
	CGM……	□	□	□
Carbohydrate Counting		□	□	□
Insulin Administration	Syringe……..	□	□	□
	Pen……	□	□	□
	Pump……	□	□	□
Can Calculate Insulin Doses		□	□	□
Glucose Management	Low Glucose……	□	□	□
	High Glucose……..	□	□	□

Self-Carry Diabetes Supplies: □ No □ Yes; Please specify items: _____

Smart Phone: □ No □ Yes

Device Independence: □ CGM □ Interpretation & Alarm Management □ Sensor Insertion □ Calibration
□ Insulin Pumps □ Bolus □ Connects/Disconnects □ Temp Basal Adjustment
□ Interpretation & Alarm Management □ Site Insertion □ Cartridge Change

Full Support: All care performed by school nurse and trained staff (as permitted by state law).
Supervision: School nurse and trained staff to assist & supervise. Guide & encourage independence.
Self-Care: Student manages diabetes independently. Support is provided upon request and as needed (emergency).

4. STUDENT RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CIRCLE ALL THAT APPLY)

Symptoms of High:

Thirsty Frequent Urination Fatigued/Tired/Drowsy Headache Blurred Vision Warm/Dry/Flushed Skin
Abdominal Discomfort Nausea/Vomiting Fruity Breath Unaware Other: _____

Symptoms of Low:

None Hungry Shaky Pale Sweaty Tired/Sleepy Tearful/Crying Dizzy Irritable Unable to Concentrate
Confusion Personality Changes Other: _____

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Other: _____

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STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____/_____/____

Has student lost consciousness, experienced a seizure or required Glucagon:

□ No □ Yes; If yes, date of last event: _____

Has student been admitted for DKA after diagnosis: □ No □ Yes; If yes, date of last event:_____

5. GLUCOSE MONITORING AT SCHOOL

Monitor Glucose:

□ Before Meals □ With Physical Complaints/Illness (include ketone testing) □ High or Low Glucose Symptoms

□ Before Exams □ Before Physical Activity □ After Physical Activity □ Before Leaving School (e.g., bus student)

□ Other: _____

CONTINUOUS GLUCOSE MONITORING (CGM)

Specify Brand & Model:

_____

Specify Viewing Equipment:

□ Device Reader □ Smart Phone □ Insulin Pump

□ Smart Watch □ iPod/iPad/Tablet

□ CGM is remotely monitored by parent/guardian. Document individualized communication plan in Section 504 or other plan to minimize interruptions for the student.

□ May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

CGM Alarms:

Low alarm: _____ mg/dL

High alarm: _____ mg/dL if applicable

Please:

- Permit student access to viewing device at all times
- Permit access to School Wi-Fi for sensor data collection and data sharing
- Do not discard transmitter if sensor falls

Perform finger stick if:

- Glucose reading is below _____ mg/dL or above _____ mg/dL
- If CGM is still reading below _____ mg/dL (**DEFAULT** 70 mg/dL) 15 minutes following low treatment
- CGM sensor is dislodged or sensor reading is unavailable. (see CGM addenda for more information)
- Sensor readings are inconsistent or in the presence of alerts/alarms
- Dexcom does not have both a number and arrow present
- Libre displays Check Blood Glucose Symbol
- Using Medtronic system with Guardian sensor

Notify parent/guardian if glucose is:

Below _____ mg/dL (<55 mg/dL **DEFAULT**)

Above _____ mg/dL (>300 mg/d **DEFAULT**)

TX Licensed Physician's Name: _____ Contact # _____

Fax # _____ Email Address (non-essential communication): _____

Other: _____

SHARYLAND ISD HEALTH SERVICES

STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____/_____/____

6. INSULIN DOSES AT SCHOOL

Insulin Administered Via:

□ Syringe □ Insulin Pen: (□ Whole Units □ Half Units) □ i-Port □ Smart Pen

□ Insulin Pump (Specify Brand & Model:_____)

□ Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA- approved device

□ Insulin Pump is using DIY Looping Technology (child/parent manages device independently, nurse will assist with all other diabetes management)

□ **DOSING** to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 6A).

Insulin Administration Guidelines

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with students that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when student does not complete their meal.

□ **Prior to Meal** (**DEFAULT**)

□ **After Meal** as soon as possible and within 30 minutes

□ **Snacking** avoid snacking _____ hours (**DEFAULT** 2 hours) before and after meals

Partial Dose Prior to Meal: (preferred for unpredictable eating patterns using **insulin pump therapy**)

□ Calculate meal dose using _____ grams of carbohydrate prior to the meal

□ Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)

□ May advance to Prior to Meal when student demonstrates consistent eating patterns.

For Injections, Calculate Insulin Dose to The Nearest:

□ Half Unit (round down for < 0.25 or < 0.75 and round up for ≥ 0.25 or ≥ 0.75)

□ Whole Unit (round down for < 0.5 and round up for ≥ 0.5)

Supplemental Insulin Orders:

□ Check for **KETONES** before administering insulin dose if BG > _____ mg/dL (**DEFAULT** >300 mg/dL or >250 mg/dL on insulin pump) or if student complains of physical symptoms. Refer to section 9. for high blood glucose management information.

□ Parents/guardians are authorized to adjust insulin dose +/- _____ units

- □ Insulin dose +/- _____ units
- □ Insulin dose +/- _____ %
- □ Insulin to Carb Ratio +/- _____ grams/units
- □ Insulin Factor +/- _____ mg/dL/unit

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6. INSULIN DOSES AT SCHOOL continued

Additional guidance on parent adjustments:

_____

_____

_____

_____

_____

_____

_____

TX Licensed Physician's Name: _____ Contact # _____

Fax # _____ Email Address (non-essential communication): _____

Other: _____

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TX Licensed Physician's Name: _____ Contact # _____

Fax # _____ Email Address (non-essential communication): _____

Other: _____

Diabetes Medical Management Plan SY 20____/20____

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6A. DOSING TABLE —HEALTHCARE PROVIDER TO COMPLETE – SINGLE PAGE UPDATE ORDER FORM

Insulin: (administered for food and/or correction)

Rapid Acting Insulin: □ Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) □ Other: _____

Ultra Rapid Acting Insulin: □ Fiasp (Aspart) □ Lyumjev (Lispro-aabc) □ Other: _____

Other insulin: □ Humulin R □ Novolin R

Meal & Times	**Food Dose**		**Glucose Correction Dose** □ Use Formula □ See Sliding Scale 6B	**□ PE/Activity Day Dose**
Select if dosing is required for meal	□ **Carbohydrate Ratio:** Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	**Fixed Meal Dose**	**Formula:** (Pre-Meal Glucose Reading minus **Target Glucose)** divided by **Correction Factor=** Correction Dose □ May give Correction dose every _____ hours as needed (**DEFAULT** 3 hours)	**Adjust:** □ **Carbohydrate Dose** □ **Total Dose** Indicate dose instructions below:
□ **Breakfast**	Breakfast Carb Ratio= _____ g/unit	**Breakfast** _____ units	□ **Target Glucose** is: _____ mg/dL & **Correction Factor** is: _____ mg/dL/unit □ **No Correction dose**	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
□ **AM Snack**	AM Snack Carb Ratio= _____ g/unit □ No Carb Dose □ No Insulin	**AM Snack** _____ units if < _____ grams	□ **Target Glucose** is: _____ mg/dL & **Correction Factor** is: _____ mg/dL/unit □ **No Correction dose**	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
□ **Lunch**	Lunch Carb Ratio= _____ g/unit	**Lunch** _____ units	□ **Target Glucose** is: _____ mg/dL & **Correction Factor** is: _____ mg/dL/unit □ **No Correction dose**	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
□ **PM Snack**	PM Snack Carb Ratio= _____ g/unit □ No Carb Dose □ No Insulin	**PM Snack** _____ units if < _____ grams	□ **Target Glucose** is: _____ mg/dL & **Correction Factor** is: _____ mg/dL/unit □ **No Correction dose**	Carb Ratio _____ g/unit Subtract _____% Subtract _____ units
□ **Dinner**	Dinner Carb Ratio= _____ g/unit	**Dinner** _____ units	□ **Target Glucose** is: _____ mg/dL & **Correction Factor** is: _____ mg/dL/unit □ **No Correction dose**	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units

6B. CORRECTION SLIDING SCALE

□ Meals Only □ Meals and Snacks □ Every _____ hours as needed

_____ to _____ mg/dL = _____ units	_____ to _____ mg/dL = _____ units	_____ to _____ mg/dL = _____ units
_____ to _____ mg/dL = _____ units	_____ to _____ mg/dL = _____ units	_____ to _____ mg/dL = _____ units
_____ to _____ mg/dL = _____ units	_____ to _____ mg/dL = _____ units	_____ to _____ mg/dL = _____ units

TX Licensed Physician's Name: _____ Contact # _____

Fax # _____ Email Address (non-essential communication): _____

Other: _____

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6C. LONG ACTING INSULIN

_____ Time	□ Lantus, Basaglar, Toujeo (Glargine) □ Levemir (Detemir) □ Tresiba (Degludec) □ Other: _____	_____ units	□ Daily Dose □ Overnight Field Trip Dose □ Disaster/Emergency Dose	Subcutaneously

6D. OTHER MEDICATIONS

_____ Time	□ Metformin □ Other: _____	_____ units	□ Daily Dose □ Overnight Field Trip Dose □ Disaster/Emergency Dose	Route _____

Signature is required here if sending ONLY this one-page dosing update.

Texas-licensed Physician Signature: _____ **Date**: _____/_____/20_____

TX Licensed Physician's Name: _____ Contact # _____

Fax # _____ Email Address (non-essential communication): _____

Other: _____

SHARYLAND ISD HEALTH SERVICES

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7. LOW GLUCOSE PREVENTION (HYPOGLYCEMIA)

Allow Early Interventions

☐ Allow Mini-Dosing of carbohydrate (i.e.,1-2 glucose tablets) when low glucose is predicted, sensor readings are dropping (down arrow) at _____ mg/dL (**DEFAULT** 80 mg/dL or 120 mg/dL prior to exercise) or with symptoms.

☐ Allow student to carry and consume snacks ☐ School staff to administer

☐ Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (**DEFAULT**)

Insulin Management (Insulin Pumps)

Temporary Basal Rate Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia.

☐ Pre-programmed Temporary Basal Rate Named _____ (Omnipod)

☐ Temp Target (Medtronic) ☐ Exercise Activity Setting (Tandem) ☐ Activity Feature (Omnipod 5)

Start: _____ minutes prior to exercise for _____ minutes duration (**DEFAULT** 1 hour prior, during, and 2 hours following exercise).

Initiated by: ☐ Student ☐ School Nurse ☐ Trained School Staff

☐ May disconnect and suspend insulin pump up to _____ minutes (**DEFAULT** 60 minutes) to avoid hypoglycemia, personal injury with certain physical activities or damage to the device (keep in a cool and clean location away from direct sunlight).

Exercise (Exercise is a very important part of diabetes management and should always be encouraged and facilitated).

Exercise Glucose Monitoring

☐ prior to exercise ☐ every 30 minutes during extended exercise ☐ following exercise ☐ with symptoms

Delay exercise if glucose is < _____ mg/dL (120 mg/dL DEFAULT)

Pre-Exercise Routine

☐ **Fixed Snack:** Provide grams of carbohydrate prior to physical activity if glucose < _____ mg/dL

☐ **Added Carbs:** If glucose is < _____ mg/dL (120 **DEFAULT**) give _____ grams of carbohydrates (15 **DEFAULT**)

☐ **TEMPORARY BASAL RATE as indicated above**

Encourage and provide access to water for hydration, carbohydrates to treat/prevent hypoglycemia, and bathroom privileges during physical activity

8. LOW GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Low Glucose below _____ mg/dL (below 70 mg/dL **DEFAULT)** or below _____ mg/dL before/during exercise (**DEFAULT** is < 120 mg/dl).

1. If student is awake and able to swallow give _____ grams of fast acting carbohydrate (**DEFAULT** 15 grams; **follow Rule of 15**). Examples include, but not limited to: 4 ounces of juice or regular soda (ensure not a sugar free or "zero" sugar drink), 4 glucose tabs, 1 small tube glucose gel. School nurse/parent may change type and amount given.
2. Check blood glucose every 15 minutes and re-treat until glucose > _____ mg/dL (**DEFAULT** is 80 mg/dL or 120 mg/dL before exercise).

STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____/_____/____

SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)

- Administer Glucagon, position student on their side and monitor for vomiting, call 911 and notify parent/guardian.
- If BG meter is available, confirm hypoglycemia via BG fingerstick.
- Do not delay treatment if meter is not immediately available.
- If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with student.

□ Glucagon Emergency Kit 1mg/mL by:	IM Injection □ 0.5 mg OR □ 1 mg
□ Gvoke PFS (prefilled syringe) by SC Injection	□ 0.5 mg □ 1.0 mg
□ Gvoke HypoPen (auto-injector) by SC Injection	□ 0.5 mg □ 1.0 mg
□ Gvoke Kit (ready to use vial and syringe, 1mg/0.2 ml) by SC injection	
□ Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector	□ Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe
□ Baqsimi Nasal Glucagon 3 mg	

9. HIGH GLUCOSE MANAGEMENT (HYPERGLYCEMIA)

Management of High Glucose over _____ mg/dL (**DEFAULT** is 300 mg/dL OR 250 mg/dl if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 30 minutes. May consume fluids in classroom. Allow frequent bathroom privileges.
2. Check for Ketones (before giving insulin correction)
   a. If **Trace or Small** Urine Ketones (0.1 – 0.5 mmol/L if measured in blood)
      - Consider insulin correction dose. Refer to the "Correction Dose" Section 6.A-B. for designated times correction insulin may be given.
      - *Can return to class and PE unless symptomatic*
      - Recheck glucose and ketones in 2 hours
   b. If **Moderate or Large** Urine Ketones (0.6 – 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.
      - Contact parents/guardian or, if unavailable, healthcare provider
      - **Administer correction dose via injection.** If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the "Blood Glucose Correction Dose" Section 6.A-B
      - If using insulin pump change infusion site/cartridge or use injections until dismissal.
      - **NO physical activity** until ketones have cleared
      - Report nausea, vomiting, and abdominal pain to parent/guardian to take student home.
      - **Call 911** if changes in mental status and labored breathing are present and notify parents/guardians.

□ Send student's diabetes log to Health Care Provider (include details): If pre-meal blood glucose is below 70 mg/dL or above 240 mg/dL more than 3 times per week or you have any other concerns.

SIGNATURES ON NEXT PAGE

TX Licensed Physician's Name: _____ Contact # _____

Fax # _____ Email Address (non-essential communication): _____

Other: _____

STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____/_____/____

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

Student's Texas-licensed Physician Signature: Date:

_____ _____/_____/20____

I, (parent/guardian) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school name) _____ to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also 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 another qualified health care professional to collaborate with my child's physician/health care provider.

Yo, (padre/tutor) _____ doy permiso a la enfermera de la escuela u otro profesional de atención médica calificado o personal capacitado en diabetes de (nombre de la escuela) _____ para realizar y llevar a cabo las tareas de cuidado de la diabetes como se describe en este Plan de control médico de la diabetes. También doy mi consentimiento para la divulgación de la información contenida en este Plan de control médico de la diabetes a todos los miembros del personal de la escuela y otros adultos que tienen responsabilidad por mi hijo/a y que puedan necesitar conocer esta información para mantener la salud y seguridad de mi hijo/a. También doy permiso a la enfermera de la escuela u otro profesional de atención médica calificado para colaborar con el médico/proveedor de atención médica de mi hijo/a.

Acknowledged and received by/ Reconocido y recibido por:

_____	_____	_____/_____/20_____
PRINT Student Name (If over 18 years old) IMPRIMA Nombre del estudiante (si tiene más de 18 años)	Signature/Firma	Date/Fecha
_____	_____	_____/_____/20_____
PRINT Parent/Guardian Name IMPRIMA Nombre del Padre/tutor	Signature/Firma	Date/Fecha
_____	_____	_____/_____/20_____
PRINT School Nurse Name IMPRIMA Nombre de Enfermera Escolar	Signature/Firma	Date/Fecha