Diabetes Management Plan and Orders

Student _____ Birth date _____ Age when diagnosed _____
Teacher/Team _____ Grade _____ Transportation: □ bus # _____ □ car rider
This plan is only valid for the school year: _____

Blood Sugar Monitoring:

Test Blood Sugar: ☐ Before Meal ☐ After Meal ☐ Before Exercise ☐ After Exercise ☐ Before Snack ☐ Before bus/dismissal
☐ If symptoms of low or high blood sugar
- Notify parent if blood sugar below _____mg/dl or higher than _____ mg/dl.
- Type of Meter: _____

Continuous Glucose Monitor (CGM): ☐ **Yes** ☐ **No type:** _____ **FDA approved to use CGM BS for treatment** ☐ **Yes** ☐ **No**

HYPOGLYCEMIA: blood sugar less than 80mg/dl

Signs and symptoms of hypoglycemia:
- Dizziness
- Hunger
- Headache
- Seizure
- Loss of consciousness
- Pallor
- Shaking
- Blurry vision
- Behavior changes
- Anxiety
- Weakness/fatigue

1. Check blood sugar. If meter is not available and child has any of the above symptoms, proceed to step 2.
2. If blood sugar less than___ mg/dl: Treat with 15 grams of fast acting carbohydrate (4 oz. juice, 6 oz. regular soda, 3-4 glucose tablets, 3 tsp of sugar. If unable to swallow safely, administer 1 tube of glucose gel to inside of cheek.
3. If blood sugar ≤ 50 mg/dl: Treat with 30 grams of fast acting carbohydrate.
4. Recheck and retreat every 15 minutes until blood sugar greater than ___mg/dl.
5. When blood sugar is above ___ mg/dl give 10-15grams complex carbohydrate (crackers with cheese, granola bar, trail mix etc.), if it is going to be more than an hour until the next meal or snack.
6. If unable/unwilling to take fast acting carbohydrate, having seizures, or is unconscious: Administer Glucagon by trained staff, call 911, and contact parent/guardian. **If student has an insulin pump, suspend or remove pump.** Give Glucagon:

Name of Glucagon: _____
Dose: □ 0.5 mg □ 1 mg □ 3 mg
Route: □ intramuscular □ subcutaneous □ intranasal

HYPERGLYCEMIA: blood sugar greater than 300mg/dl

Signs and symptoms of hyperglycemia:
- Increased thirst
- Hunger
- Irritability
- Nausea/Vomiting
- Frequent urination
- Fatigue
- Double vision
- Abdominal pain

1. Check blood sugar.
2. If blood sugar is over 300 mg/dl and greater than 2 hrs since last insulin dose, give insulin per sliding scale or bolus via pump.
3. Check ketones. If ketones are present, call parents. **STUDENT SHOULD NOT EXERCISE**
4. Give 8-16 oz. of water per hr**.**
5. Recheck blood sugar in ___ hr(s) and treat with correction scale insulin, as needed. * See below for pump.
6. When having symptoms of nausea and vomiting student will be released from school to parent/guardian.
7. No exercise if blood sugar is higher than ____-mg/dl with or without ketones.

* When student has insulin pump: Blood sugar greater than 300 mg/dl with ketones or 2 consecutive unexplained blood sugars greater than 300 mg/dl (with or without ketones), may indicate a malfunction in the pump. Student may require insulin via injection and/or new infusion site. **PARENTS MUST BE NOTIFIED.**

Insulin Administration

Route: Insulin Pen_____ Syringe_____ Pump_____ Type: _____ If pump failure, use correction scale
Insulin type: Long acting insulin: _____; _____units daily at _____
Insulin type: Fast acting insulin: _____

Correction Scale: (ONLY to be used every 2 hours)

If BS _____give _____units of insulin
If BS _____give _____units of insulin
If BS _____give _____units of insulin
If BS _____give _____units of insulin
If BS _____give _____units of insulin

If BS _____give _____units of insulin
If BS _____give _____units of insulin
If BS _____give _____units of insulin
If BS _____give _____units of insulin
If BS _____give _____units of insulin

Max Correction is _____

Carbohydrate Counting:

- **Meals**: Carbohydrate recommendation for meals: _____ _____ units of insulin per_____ grams of carbohydrates at meals
- Bolus for carbs should occur immediately ☐ Before meal ☐ After meal ☐ ½ bolus before & ½ bolus after
- **Snacks**: Student to have scheduled snack: ☐ yes ☐ no If yes, when? _____
  ☐ If snacks greater than _____ grams of carbohydrates cover with insulin ☐ No insulin overage for snacks.

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Student_____ DOB_____

Parent has permission to make adjustments to diabetes care and/or treatment **temporarily or situationally.** ☐ Yes ☐ No
If permanent changes are made/needed, parents must obtain updated orders from their provider.

Totally independent in all aspects of care ☐ Yes ☐ No **If you answered yes, skip to signatures**

Supervision and documentation of blood glucose only ☐ Yes ☐ No

Independently tests blood sugar.	☐ Yes ☐ No	Administers insulin independently.	☐ Yes ☐ No
Independently counts carbohydrates.	☐ Yes ☐ No	Self injects with verification of dosage.	☐ Yes ☐ No
Needs assistance with pump management.	☐ Yes ☐ No	Injection to be done by trained staff	☐ Yes ☐ No
Independently manages pump boluses.	☐ Yes ☐ No	Self treats mild hypoglycemia.	☐ Yes ☐ No
Independently inserts new infusion set	☐ Yes ☐ No	Tests and interprets urine/blood ketones.	☐ Yes ☐ No
Troubleshoots all alarms.	☐ Yes ☐ No		

Physician Authorization for Medication Administration and Specialized Health Care Procedures:

Physician's signature: _____ Physician's name printed: _____

Office telephone: _____ Date: _____

Parent/Guardian Authorization for medication administration, specialized health care procedures and release of information:

- **Student's parent/guardian knows of this request and is in full agreement of the plan of care, the administration of the medications and procedures specified above during the school day. He/She agrees to provide all necessary supplies needed to test blood sugar and to treat high or low blood sugars on the first day back to school. He/She further understands that this should include blood sugar monitor, test strips and lancets, insulin pump supplies such as infusion sets, reservoirs, batteries and back up insulin with syringes/insulin pen, ketostix, snacks, juice and a water bottle and understands that all insulin vials or insulin pen refills must be replaced every 30 days once opened. Please note that school nurses and trained staff cannot change pump infusion sites or CGM sensors.**
- **Furthermore school nurses and trained staff cannot follow CGM on personal devices.**
- **I have been made aware of the Standards of Care for Students with Diabetes and how to access it.**
- **I hereby give permission for my child's school to exchange specific, confidential medical information with the physician listed above on my child to develop more effective ways of providing for the healthcare needs of my child in school.**
- **The parent/guardian releases the School Board, its agents and employees, from any and all liability that may result from his/her child taking these prescription medications and/or receiving these specialized health care procedures and is aware that these orders expire no later than the last day of school this year.**

Parent/Guardian's signature: _____ Date: _____

Parent/Guardian's name printed: _____

Telephone #: _____ Telephone #: _____

Student contract for Self-administered Medication:

- I will be responsible for my own diabetic supplies at school. Where are Diabetic supplies kept during school day? _____
- I agree to use my diabetic supplies/medication in a responsible manner, in accordance with my licensed health care provider's orders.
- I will notify the School Nurse or main office if I am having more difficulty than usual with my diabetes.
- I will not allow any other person to use my diabetic supplies/medication.

Student's Signature: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____ **3/2020apl**