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.

Diabetes Management Plan and Orders

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: _____

Autorización de Padres/Tutores para la administración de medicamentos, procedimientos de atención médica especializados y divulgación de información:

- **El padre/tutor del estudiante conoce esta solicitud y está en acuerdo total con el plan de cuidado, la administración de los medicamentos y procedimientos descritos arriba durante el día escolar. Él/ella se compromete a proporcionar todos los suministros necesarios para analizar el azúcar en la sangre y tratar los niveles altos o bajos de azúcar en sangre el primer día de regreso a la escuela. Él/ella entiende que esto debe incluir un monitor del azúcar de sangre, tiras de prueba y lancetas, suministros para la bomba de la insulin, tales como conjuntos de la infusión, embalses, baterías y la insulina de reserva con las jeringuillas/ lapiceros de insulina, ketostix, aperitivos, jugo, botella de agua y entiende que todos los frascos de insulina o los recambios de la lápiz de insulina se deben reemplazarse cada 30 días una vez que están abiertos. Tenga en cuenta que las enfermeras escolares y el personal no pueden cambiar los sitios de infusión de la bomba ni los sensores CGM.**
- **Además, las enfermeras escolares y el personal capacitado no pueden seguir a CGM en dispositivos personales.**
- **He sido informado de las Estándares de Cuidado para Estudiantes con Diabetes y cómo acceder a ella.**
- **Por la presente doy permiso para que la escuela de mi hijo/a intercambie información médica específica, confidencial con el médico mencionado anteriormente sobre mi hijo/a para desarrollar la manera más efectivas de proveer las necesidades de atención médica de hijo/a mientras asiste a la escuela.**
- **El padre/tutor libera a la Junta Escolar, sus agentes y empleados, de cualquier y toda responsabilidad que pueda resultar de que su hijo/a tome estos medicamentos recetados y/o reciba estos procedimientos de atención médica especializados y es consciente de que estos pedidos expiran a más tardar el último día de escuela este año.**

Firma del padre/guardián: _____ Fecha: _____

Nombre del padre/guardián impreso: _____

Teléfono #: _____ Teléfono #: _____

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: _____ **4/2020aw**