American Diabetes Association.
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Safe at School®

Diabetes Medical Management Plan

(Add student photo here.)

SCHOOL YEAR:

STUDENT LAST NAME: FIRST NAME: DOB:

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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

Student First Name: Last Name: DOB: Student's Cell #: Diabetes Type: Date Diagnosed: Month: Year:

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

Home Room: School Point of Contact: Contact Phone #:

STUDENT'S SCHEDULE Arrival Time: Dismissal Time:

Travels to school by (check all that apply):
- ☐ Foot/Bicycle
- ☐ Car
- ☐ Bus
- ☐ Attends Before School Program

Meals Times:
- ☐ Breakfast
- ☐ AM Snack
- ☐ Lunch
- ☐ PM Snack
- ☐ Pre Dismissal Snack

Physical Activity:
- ☐ Gym
- ☐ Recess
- ☐ Sports
- ☐ Additional information:

Travels to:
- ☐ 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 method:

Parent/Guardian #2: Relationship:

Cell #: Home #: Work #:

E-mail Address:

Indicate preferred contact method:

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.

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

3. SELF-MANAGEMENT SKILLS (DEFINITIONS BELOW)

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

Self-Carry Diabetes Supplies: Yes No Please specify items:
Smart Phone: Yes No

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: Trained staff to assist & supervise. Guide & encourage independence.
Self-Care: Manages diabetes independently. Support is provided upon request and as needed.

4. STUDENT RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CHECK 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:

Has student lost consciousness, experienced a seizure or required Glucagon: Yes No If yes, date of last event:
Has student been admitted for DKA after diagnosis: Yes No 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 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)

Section 1-5 completed by Parent/Guardian

Name of Health Care Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

6. INSULIN DOSES AT SCHOOL - HEALTHCARE PROVIDER TO COMPLETE

Insulin Administered Via:

- Syringe
- i-Port
- Other
- Insulin Pen (Whole Units Half Units)
- 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

Additional guidance on parent adjustments:

Diabetes Medical Management Plan

STUDENT LAST NAME: FIRST NAME: DOB:

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 if < ____ grams	**AM Snack** ____ units	**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 if < ____ grams	**PM Snack** ____ units	**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

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.

Diabetes Provider Signature: **Date:**

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

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 Trained School Staff School Nurse

- 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). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.
   - School nurse/parent may change 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).

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

Diabetes Medical Management Plan

STUDENT LAST NAME: FIRST NAME: DOB:

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

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider: Date:

I, (parent/guardian) give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) 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.

Acknowledged and received by:

Student's Parent/Guardian: Date:

Acknowledged and received by:

School Nurse or Designee: Date:

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

WAVERLY COMMUNITY SCHOOLS
Pride. Tradition. Excellence.

Active for School Year: _____

STUDENT MEDICATION REQUEST FORM

This form must be *completed in full and returned with a physician's signature* to current school office before administration of medication can take place within the school. *OTC medications also require a physician's signature.*

Student Name & DOB:	**School & Grade:**
Parent/Guardian:	**Phone:**
Parent/Guardian:	**Phone:**
Name of Prescription or OTC Medication:	
Form of Medication (circle one): Tablet/Capsule Liquid Inhaler Medi-pen Other: _____	
Time to be administered:	
Is this medication for episodic or emergency events only? (circle one): Yes No	
Is the student able to self-carry this medication? (circle one): Yes No	
Possible side effects from medication:	
Health Care Provider Signature: **Printed Name:**	**Phone:**
Preferred Hospital:	**Fax:**
Emergency Contact:	**Phone:**

I give permission for school personnel to share this information, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and equipment devices. I understand and agree that when school personnel administer medication to my child as indicated above, I will not hold the personnel and school district liable in any criminal action or for civil damages. Reference: Act #157, Public Acts of 1971, effective 11/24/1971, Section 378.

All medications must be collected by a parent or guardian within one week of the last day of classes for students. Any medications left after that time will be properly disposed of.

_____

Parent Signature **Date**

School Office Use Only	Administration Office Use Only
Date Received:	**Date Received from Building:**
Location of Medication:	**Date Recorded:**
Reminder: **Scan/Email to School Nurse & Administration Office**	**Reminder:** **Set Alert in PowerSchool, Upload to CEO**