Diabetes Management Plan and School Treatment Authorizations
(School Year: July 1st – June 30th)**for the School Year** (or dates provided)**:**

This plan outlines the diabetes management for children and adolescents to be used at home or in any community or school setting. This plan is *in accordance with CT State Law and Regulations 10-212a, Administration of Medication in School*

Part 1: To be completed by parent/guardian and reviewed with diabetes provider

Name: _____ DOB: _____
Diabetes Center: _____ Phone: _____
Primary Care Provider: _____ Phone: _____
Other health conditions: _____
Diabetes Medication at home: _____ ☐ Has Medical Alert Bracelet

Self-care skills

BG= Blood Glucose

	N/A	Independent	May require some help or supervision	Requires direct assistance by nurse or trained staff
BG monitoring: times, technique, and communication	☐	☐	☐	☐
Knows meaning of BG results and what to do	☐	☐	☐	☐
Draw up or set pen for correct insulin dose:				
• For amount for carbohydrates consumed	☐	☐	☐	☐
• Based on sliding scale	☐	☐	☐	☐
Insulin injection technique	☐	☐	☐	☐
Count carbohydrates	☐	☐	☐	☐
Pump Specific				
Calculate and administer correction bolus	☐	☐	☐	☐
Calculate and set temporary basal rate	☐	☐	☐	☐
Troubleshoot alarms and malfunctions	☐	☐	☐	☐
Disconnect pump	☐	☐	☐	☐
Reconnect pump to infusion set	☐	☐	☐	☐
Change batteries	☐	☐	☐	■
Prepare reservoir and tubing	☐	☐	☐	■
Calculate and set basal profiles/rates	☐	☐	☐	■
Insert tubing set	☐	☐	☐	■
Change site	☐	☐	☐	■

These skils require some degree of student competence &/or family responsibility

Blood Glucose Monitoring

Student's BG goal : _____ to _____ Mg/dl

Check BG at times checked below AND for signs & symptoms of Hyper or Hypo Glycemia

☐ Before meals
☐ Before snacks
☐ Mid-morning
☐ Before P.E. or Recess
☐ After P.E. or Recess
☐ Before Dismissal
☐ Before standardized or major exam
☐ Other:

- Clean hands or site as needed
- Use only fingers if low blood sugar suspected
- No alcohol for skin preparation
- Change lancet at least daily

When to call for help: Call parent/guardian and/or diabetes provider if needed:

- Persistent BG < 70 despite prescribed treatment
- Suspected pump or insertion site failure
- 2 consecutive BG > 250, 2 hrs apart &/or moderate to large ketones
- Daily episodes of BG below 70 or above 250 for 3 consecutive school days
- Questions or concerns

Part 2: Insulin Therapy: To be completed by MD /DO/APRN/PA

- Parent/guardian is authorized to make all changes of pump settings throughout the school year
- RN may increase or decrease insulin injection doses +/- 5 units in collaboration with parent/guardian for temporary changes in condition, such as illness. Changes that persist greater than 5 school days require an updated medical authorization signed by provider and parent

PUMP: Settings stored in pump, follow pump model procedures Type/Model:

Insulin Type: ☐ Humalog ☐ Novolog ☐ Apidra

Management Options for Students who use Continuous Subcutaneous Insulin Infusion (CSII)

☐ Meal bolus and correction for ☐ Lunch and Snacks ☐ Lunch only ☐ Dinner (field trips or after hours)
☐ Meal bolus only for snacks
☐ Correction dose PRN for BG > _____ Mg/dL (Do not give within 2-3 hours of another bolus
☐ Other:

Planned /Sports Activities: ☐ May disconnect from pump during activity < 1hr ☐ Suspend pump during activity (< 1hr)
Set temporary basal rate at: or ☐ per student if independent ☐ No adjustment necessary

- ***DO NOT OVERRIDE PUMP WITHOUT AUTHORIZATION*** (protects against overcorrection and hypoglycemia)

Assess Pump or Site Failure: For 2 consecutive BG > 250, 2 hours apart &/or moderate to large ketones

- Back-up insulin by syringe or pen must be kept in school to use if pump or site failure occurs:
- For site failure only, use pump to determine insulin doses
- For pump failure, administer Insulin injection (***as stated below***) by ☐ Sliding Scale OR ☐ Correction Factor
  - Before meals and/or every _____ hours

INJECTIONS **Insulin Type:** ☐ Humalog ☐ Novolog ☐ Apidra ☐ Other:
Delivery Device: ☐ Syringe ☐ Insulin Pen

Management Options for Students who use Multiple Dose Insulin Injections (select those that apply)

☐ Fixed insulin dose at home (amount/times): _____
☐ Fixed insulin dose required at school (amount/times): _____
☐ Carbohydrate goals for snacks/meals, fixed insulin dose at home or in school
☐ Sliding scale for meals, no carbohydrate counting or coverage
☐ Carbohydrate Coverage using insulin:carb ratio with ☐ Sliding Scale OR ☐ Correction Factor (see formula below)

Carbohydrate Goals (for fixed insulin doses or as a guideline for individual students)

Breakfast:	AM Snack:	Lunch:	Afternoon Snack:
Dinner:	Other:		

OR

Carbohydrate Coverage (insulin:carb ratio) ☐ Before Snacks ☐ Before Meals

Insulin: Carb Ratio Formula 1 unit of insulin per _____ grams of carbohydrates **AND** (select one)

☐ **Sliding Scale***: may be used with or without carb coverage*

BG Range (mg/dL)			Give SC insulin
_____	≤	_____	_____ units
_____	to	_____	_____ units
_____	to	_____	_____ units
_____	to	_____	_____ units

OR

☐ **Calculate Correction (insulin sensitivity) Factor**

Target BG: _____ Correction factor: _____

Correction factor formula

$$\frac{\text{Current BG} - \text{Target BG}}{\text{Correction Factor}} = \text{Units of insulin}$$

Meal Coverage Guidelines:

- If BG< 70, follow hypoglycemia protocol, re-check in 20 min
- If BG ≥70 cover with insulin and send to lunch If
- If BG remains <70 may send to lunch and cover with insulin after student eats

Part 3:

Hypoglycemia Management (BG < 70mg/dL)

Usual symptoms include: dizziness, confusion, sweating, shaky, hunger, fatigue (circle any that are commonly specific to student) or other: _____

- Location and nurse involvement for hypoglycemia treatment is based on severity of episode and student's self-management skills &/or IHCP, standard management options include:
  - Give 12-16 gms of fast-acting carbohydrate (4oz juice, 3-4 glucose tabs, etc.)
    - Give 1 tube of glucose gel (15gms) between cheek and gum if symptoms require urgent effect
  - Re-test BG in 20 minutes (wait 30 minutes if using pump) to confirm level > 70mg/dL, if not repeat with rapid-acting carbs or lunch/meal (see meal coverage guidelines)
    - *Repeat BG may not be indicated for students who can demonstrate symptoms as a guide to re-check BG*

Administer glucagon : ☐ 0.5mg IM/SC **or** ☐ 1mg IM/SC **PRN for severe and symptomatic hypoglycemia, including unable to swallow, seizure activity, or unconsciousness; Call 911 if administered**

- *Parent guardian responsible for providing glucagon to school if ordered*
- *Field Trip management (including glucagon option) to be assessed by school nurse in collaboration with parent/guardian and diabetes provider (as needed) on an individual basis and in consideration of EMS response times*

Hyperglycemia (BG> 250mg/dL) & Ketones Management

- Check urine for ketones if 2 consecutive BG > 250mg/dL &/or has nausea or vomiting
  - If ketones negative, trace, or small and feels well, continue plan and return to class or gym
  - If ketones are moderate or large &/or 2 consecutive BG >250mg/dL:
    - call parent/guardian, if not available, call diabetes provider for insulin dose
    - Follow pump protocol to assess for pump or site failure
    - Hold P.E. or recess until ketones resolved
- Encourage drinking sugar -free (0 carbohydrate) beverage, preferably water, 8 oz every 30-60 minutes
- Do not withhold food

☐ Other:

Prescriber's Signature: _____

Date: _____

Printed or stamped, include phone and fax:

Parent/Guardian Authorization: I hereby request that the above ordered medication and diabetes management procedures be administered by school personnel. I also give my consent for the exchange of information between the prescribing health care provider and school nurse, as needed for the safe implementation of this plan in school.

- ***Parent/Guardian responsible for providing all diabetes medical supplies and snacks/juice to school***
- **School Delay:** Parent/Guardian must notify the school nurse/responsible staff of any change in schedule or insulin

Parent/Guardian Signature: _____ **Date:** _____

Addendum to Diabetes Management Plan and School Treatment Authorizations: for changes that persist greater than 5 school days and require medical provider authorization

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_____ to	_____	_____ units
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4.10.12/MC