

**ROCHESTER COMMUNITY SCHOOLS
DIABETES Care**

Child's picture
Face only

This form must be completed, signed, and ATTACHED to a Diabetes Medical Action Plan (MAP). Your child's endocrinologist will choose to either use their own MAP template, OR the Diabetes MAP template listed on the RCS website.

Student's Name: _____ School: _____
 Date of birth: _____ Age: _____
 Grade: _____ Teacher: _____

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2023-2024 school year.

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

PARENT/GUARDIAN CONSENT

I, (parent/guardian), _____, request that my child, _____, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Bus # _____
 Driver: _____
 Route # _____
 Medical File _____
 Transportation Office Use ONLY if needed

School-based Medical Management Plan for the Student with Diabetes Mellitus

To be completed by Parent/Guardian

Student Name: _____ Birthdate: _____ Grade: _____
 Address: _____
 Mother/Guardian: _____ Phone: (home) _____ (cell) _____
 Father/Guardian: _____ Phone: (home) _____ (cell) _____
 Other Emergency Contact: _____ Phone: _____ Relationship: _____
 Diabetes Health Care Provider: _____ Phone: _____

To be completed by Diabetes Team

Date of Diabetes Diagnosis: _____ Type 1 Type 2 Other: _____

SECTION I - Routine Management

Glucose Levels:

Monitoring method: Continuous glucose monitor (CGM) Type _____ **OR** Finger Stick
 Preferred location: Classroom Office Where convenient
 Glucose check performed by: Student, Independently Student, Supervised **OR** Designated School Personnel
 Check prior to: Breakfast Snack Lunch Before PE/Recess Before leaving school
 Ensure that glucose level is above 100 before physical activity or boarding the bus Other: _____
 Always: Check when symptomatic Perform finger stick if symptoms do not match CGM values

❖ If glucose level is low (< _____ or < _____ with symptoms), see Section III, Low Glucose Level (Hypoglycemia)

❖ If glucose level is high (> _____), see Section IV, High Glucose Level (Hyperglycemia)

Insulin Administration: (Type of Insulin per Medication Administration Authorization Form, see Section II)

Preferred administration location: Classroom Office Where convenient
 Pen/Syringe - Dosing per: Card Chart Scale InPen* PUMP* *All settings pre-programmed by parent
Breakfast: Prior to Immediately after **Lunch:** Prior to Immediately after **Snack (carb coverage only):** Prior to NA
 Immediately after Immediately after Immediately after

Insulin dosage calculated by: Student, Independently Student, Supervised **OR** Designated School Personnel
 Student will determine all carb counts independently **OR** Family will provide carb counts to school staff daily
 For foods provided by school nutrition services, school staff will ensure student/family has access to carb counts

Insulin administered by: Student, Independently Student, Supervised **OR** Designated School Personnel

Adjustments to Insulin Dosing:

- Parents/Guardians have sufficient training and experience and are authorized by the prescriber to submit written requests to Designated School Personnel for insulin dosing adjustments within the following parameters:
 - Yes No Adjust correction/sensitivity factor within the following range: 1 unit: _____ to 1 unit: _____ (Target Glucose: _____)
 - Yes No Adjust insulin-to-carbohydrate ratio within the following range: 1 unit: _____ to 1 unit: _____
 - Yes No Increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.
- Designated School Personnel should contact provider if parents request insulin dosing adjustments > _____ times/week.
- Written communication between Provider & Parent** (e.g. emails, clinic visit summary, etc.) may be used to adjust insulin dosing until updated Insulin Dosing Tool is received by the Designated School Personnel.



Student Name: _____

This Plan expires June 30, 20__

SECTION II – Medication Administration Authorization (MAA) Form

This form must be completed fully in order for schools to administer the required medication. The school nurse (RN) will call the prescriber, as allowed by HIPAA, if questions arise about the student’s medications and/or related diabetes care.

Prescriber’s Authorization:

Student Name: _____ Date of Birth: _____ Grade: _____

1. **Medication Name:** Insulin: Admelog Humalog/Lispro Novolog/Aspart Apidra Fiasp

Dose: Per Accompanying Insulin Dosing Tool

Route: Pen/Syringe (Insulin dosing per card chart scale InPen)

PUMP (All settings pre-programmed into pump by parent)

InPen (All settings pre-programmed into app by parent)

Time: Breakfast: Prior to Immediately after

Lunch: Prior to Immediately after

Snack: Prior to Immediately after

Potential Side Effects: _____

Student may self-carry insulin: Yes No **Student may self-administer insulin:** Yes No

2. **Medication Name:** Glucagon

Route & Dose: Injection, Glucagon/Glucagen/Gvoke PFS: 0.5 mg
 1.0 mg

Auto-Injection, Gvoke HypoPen: 0.5mg/0.1mL

1mg/0.2mL

Nasal, Baqsimi Glucagon Nasal Powder: 3mg

Time: When severe low glucose levels are suspected as indicated by unconsciousness, seizure, or extreme disorientation with inability to safely swallow oral quick-acting glucose.

Potential Side Effects: Nausea, Vomiting, Rebound Hyperglycemia, Other: _____

Student may self-carry Glucagon: Yes No

Please see attached supplemental MAA Form for additional medication orders. Additional training provided by a RN, PA, physician, or Certified Diabetes Educator to Designated School Personnel is required.

Prescriber’s Signature: _____ Date: _____

(No stamped signatures, please)

Print Name/Title: _____ NPI#: _____

Address: _____

Phone: _____ FAX: _____

Parent/Guardian Authorization:

I request Designated School Personnel to administer the medications as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medications at school. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Reviewed by RN, PA, Physician, or Certified Diabetes Educator providing training to Designated School Personnel:

Signature/Title

Date

SECTION III - Responding to a Low Glucose Level (Hypoglycemia)

Below are common symptoms that may be observed when glucose levels are **low**.

Reminder: These symptoms can change and some students may not display any symptoms.

Parents **may** choose to circle their child's most common symptoms.

Symptoms of a Low Glucose Level (Hypoglycemia)	
Shaky Weak Sweaty Rapid heartbeat Dizzy Hungry Headache Lack of coordination Seizure Tiredness Loss of consciousness Pale Confusion Irritability/Personality changes Continuous Glucose Monitor (CGM) alarm/arrows Other: _____	
Actions for Treating Hypoglycemia	
Treatment for Mild to Moderate Hypoglycemia	Treatment for Severe Hypoglycemia
<p>Notify School Nurse or Designated School Personnel as soon as you observe symptoms. If possible, check glucose level via finger stick.</p> <p>Do NOT send student to office alone!</p> <p>Treat for hypoglycemia if glucose level is: <input type="checkbox"/> less than _____ or less than _____ with symptoms.</p> <p>WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.</p>	<p>Student is:</p> <ul style="list-style-type: none"> ✓ Unconscious ✓ Having a seizure ✓ Having difficulty swallowing <p>Follow Emergency Steps</p> <ol style="list-style-type: none"> 1. Administer Glucagon 2. Call 9-1-1 3. Activate MERT (Medical Emergency Response Team)
"Rule of 15"	Administer Glucagon
<ul style="list-style-type: none"> <input type="checkbox"/> Treat with 15 grams of quick-acting glucose (4 oz. juice or 3-4 glucose tabs) <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> <input type="checkbox"/> Treat with 30 grams of quick-acting glucose (8 oz. juice or 6-8 glucose tabs) if glucose level is less than _____ <input type="checkbox"/> Wait 15 minutes. Recheck glucose level. <input type="checkbox"/> Repeat quick-acting glucose treatment if glucose level is less than _____ mg/dL. <input type="checkbox"/> Contact the student's parents/guardians. <p>Then:</p> <ul style="list-style-type: none"> <input type="checkbox"/> If an hour or more before next meal, give a snack of protein and complex carbohydrates <input type="checkbox"/> If mealtime and no difficulty swallowing, monitor and allow student to eat lunch while waiting to recheck glucose level. <input type="checkbox"/> Once glucose level is greater than _____ and student has finished eating lunch, give insulin to <u>cover meal carbs only.</u> 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Stay with student, protect from injury, turn on side <input checked="" type="checkbox"/> Do not put anything into the student's mouth <input type="checkbox"/> Suspend or remove insulin pump (if worn) <input checked="" type="checkbox"/> Administer Glucagon Per MAA Form: <ul style="list-style-type: none"> <input type="checkbox"/> Injection, Glucagon/Glucagen/Gvoke PFS: <ul style="list-style-type: none"> <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1.0 mg <input type="checkbox"/> Auto-Injection, Gvoke HypoPen: <ul style="list-style-type: none"> <input type="checkbox"/> 0.5mg/0.1ml <input type="checkbox"/> 1mg/0.2ml <input type="checkbox"/> Nasal, Baqsimi Glucagon Nasal Powder: <ul style="list-style-type: none"> <input type="checkbox"/> 3mg <input type="checkbox"/> Implement Medical Emergency Response: <ul style="list-style-type: none"> ✓ Take AED and any emergency medical supplies to location; ✓ Inform Central Administration of Emergency; ✓ Contact parents; Meet them in the parking lot; ✓ Meet the ambulance/direct traffic; ✓ Provide copy of student medical record to EMS; ✓ Control the scene; ✓ Document emergency and response on Emergency Response/Incident Report form; ✓ Conduct debriefing session of incident and response following the event.

SECTION IV - Responding to High Glucose Levels (Hyperglycemia)

Below are common symptoms that may be observed when glucose levels are **high**.

Reminder: These symptoms can change and some students may not display any symptoms.

Parents **may** choose to circle their child's most common symptoms.

Symptoms of a High Glucose Level (Hyperglycemia)	
Increased thirst Increased urination Tiredness Increased appetite Decreased appetite Blurred Vision Headache Sweet, fruity breath Dry, itchy skin Achiness Stomach pain/nausea/vomiting Seizure Loss of consciousness/coma Continuous Glucose Monitor (CGM) alarm/arrows Other: _____	
Actions for Treating Hyperglycemia	
Treatment for Hyperglycemia	Treatment for Hyperglycemia Emergency
<p>Notify School Nurse or Designated School Personnel as soon as you observe symptoms.</p> <p><input type="checkbox"/> For glucose level less than 300:</p> <ul style="list-style-type: none"> ✓ If not mealtime – do not give correction dose of insulin, offer water, return to normal routine if feeling well ✓ If mealtime, give insulin as prescribed (see Section I, Routine Management, Insulin Administration) <p><input type="checkbox"/> For glucose level 300 or greater:</p> <ul style="list-style-type: none"> ✓ If mealtime, give insulin as prescribed (see Section I, Routine Management, Insulin Administration) ✓ Have student check ketones <p><input type="checkbox"/> Positive Ketones:</p> <ul style="list-style-type: none"> ✓ Call parent/guardian <ul style="list-style-type: none"> ▪ Trace or Small - attempt to flush, remain in school if feeling well and no vomiting ▪ Moderate or Large - parent pick-up immediately ✓ Give 8-16 oz. of water hourly ✓ No exercise, physical education, or recess ✓ Recheck ketones at next urination ✓ If on pump, check infusion set/pump site: <ul style="list-style-type: none"> ▪ Is tubing disconnected? ▪ Is there wetness around the pump site, etc.? <p><input type="checkbox"/> Negative Ketones:</p> <ul style="list-style-type: none"> ✓ If not mealtime - offer water, return to normal routine if feeling well <p><input type="checkbox"/> If no ketone strips are available:</p> <ul style="list-style-type: none"> ✓ Treat as Positive Ketones ✓ Request strips from family 	<p>Call 9-1-1 Activate Medical Emergency Response</p> <p><input type="checkbox"/> Call 9-1-1 if severe symptoms are present. Severe symptoms may include:</p> <ul style="list-style-type: none"> ✓ Abdominal pain ✓ Nausea/Repetitive Vomiting ✓ Change in level of consciousness ✓ Lethargy <p><input type="checkbox"/> Implement Medical Emergency Response:</p> <ul style="list-style-type: none"> ✓ Take AED and any emergency medical supplies to location; ✓ Inform Central Administration of Emergency; ✓ Contact parents; Meet them in the parking lot; ✓ Meet the ambulance/direct traffic; ✓ Provide copy of student medical record to EMS; ✓ Control the scene; ✓ Document emergency and response on Emergency Response/Incident Report form; ✓ Conduct debriefing session of incident and response following the event.

Parent/Guardian Signature
(Void if not signed)

Date

Physician Signature

Date



Student Name: _____

This Plan expires June 30, 20__

To be completed by Trainer of Student-specific School Health (SSH) Team in collaboration with all SSH Team members.

SECTION IV - Food and Miscellaneous

- Snack daily at: _____ Snack as needed for low glucose level Allow unlimited access to food
- Allow unlimited access to water or bathroom Have 15 grams of quick-acting glucose available at site of physical activity
- For special occasions that involve food: always contact parent for guidance **OR** student can self-manage
- Out of classroom, student will travel with: buddy adult
 - always **OR** when support is requested or is obviously needed
- Fieldtrips - Student will be accompanied by trained school personnel, unless parent volunteers to attend (parent attendance not required)
- Plan for access to food and appropriate support during School Emergencies developed/implemented
- Record all care provided/send documentation home: Weekly When requested by parent Other: _____

Location of Glucagon (Glucagon/Gvoke/Baqsimi): In Office In Classroom With Student Other: _____

Location of Other Diabetes Supplies (see attached list): In Office In Classroom With Student Other: _____

School Name: _____ Principal: _____

School Address: _____

SSH Team consists of:

Parent, Student, Designated School Personnel

AND

RN, Physician, PA, or Certified Diabetes Educator (Trainer)

The following Designated School Personnel have received training to support implementation of this plan:

Name

Title

Name

Title

Name

Title

Name

Title

Name

Title

Training provided by:

Signature/Title

Date