

Kingsway Regional School District

Diabetes Medical Management Plan

Valid for 1 School Year: _____

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of plan: _____

Student information

Student's name: _____ Date of birth: _____
 Date of diabetes diagnosis: _____ ☐ Type 1 ☐ Type 2 ☐ Other: _____
 School: _____ School phone number: _____
 Grade: _____ Homeroom teacher: _____
 School nurse: _____ Phone: _____

Contact information

Parent/guardian 1: _____
 Address: _____
 Telephone: Home: _____ Work: _____ Cell: _____
 Email address: _____

Parent/guardian 2: _____
 Address: _____
 Telephone: Home: _____ Work: _____ Cell: _____
 Email address: _____

Student's physician/health care provider: _____
 Address: _____
 Telephone: _____ Emergency number: _____
 Email address: _____

Other emergency contacts:

Name: _____ Relationship: _____
 Telephone: Home: _____ Work: _____ Cell: _____

Checking blood glucose

Brand/model of blood glucose meter: _____

Target range of blood glucose:

Before meals: ☐ 90–130 mg/dL ☐ Other: _____

Check blood glucose level:

- ☐ Before breakfast ☐ After breakfast ☐ _____ Hours after breakfast ☐ 2 hours after a correction dose
☐ Before lunch ☐ After lunch ☐ _____ Hours after lunch ☐ Before dismissal
☐ Mid-morning ☐ Before PE ☐ After PE ☐ Other: _____
☐ As needed for signs/symptoms of low or high blood glucose ☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Side of fingertip ☐ Other: _____

Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

- ☐ Independently checks own blood glucose
☐ May check blood glucose with supervision
☐ Requires a school nurse or trained diabetes personnel to check blood glucose
☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM): ☐ Yes ☐ No Brand/model: _____

Alarms set for: Severe Low: _____ Low: _____ High: _____

Predictive alarm: Low: _____ High: _____ Rate of change: Low: _____ High: _____

Threshold suspend setting: _____

Additional information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level.
If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-care CGM Skills	Independent?	
The student troubleshoots alarms and malfunctions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do and is able to deal with a HIGH alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do and is able to deal with a LOW alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student can calibrate the CGM.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The student should be escorted to the nurse if the CGM alarm goes off: ☐ Yes ☐ No

Other instructions for the school health team: _____

Hypoglycemia treatment

Student's usual symptoms of hypoglycemia (list below): _____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____mg/dL, give a quick-acting glucose product equal to _____grams of carbohydrate.

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____mg/dL.

Additional treatment: _____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- Position the student on his or her side to prevent choking.
- Give glucagon: ☐ 1 mg ☐ ½ mg ☐ Other (dose) _____
 - Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
 - Site for glucagon injection: ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: _____
- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Contact the student's health care provider.

Hyperglycemia treatment

Student's usual symptoms of hyperglycemia (list below): _____

- Check ☐ Urine ☐ Blood for ketones every ____ hours when blood glucose levels are above _____mg/dL.
- For blood glucose greater than _____mg/dL AND at least ____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _____mg/dL.
- For insulin pump users: see **Additional Information for Student with Insulin Pump**.
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ounces per hour.

Additional treatment for ketones: _____

- Follow physical activity and sports orders. (See Physical Activity and Sports)

If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

Insulin therapy

Insulin delivery device: ☐ Syringe ☐ Insulin pen ☐ Insulin pump

Type of insulin therapy at school: ☐ Adjustable (basal-bolus) insulin ☐ Fixed insulin therapy ☐ No insulin

Insulin therapy (continued)

Adjustable (Basal-bolus) Insulin Therapy

- Carbohydrate Coverage/Correction Dose: Name of insulin: _____
- Carbohydrate Coverage:
Insulin-to-carbohydrate ratio: _____ *Lunch:* 1 unit of insulin per _____ grams of carbohydrate
Breakfast: 1 unit of insulin per _____ grams of carbohydrate *Snack:* 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example

$$\frac{\text{Total Grams of Carbohydrate to Be Eaten}}{\text{Insulin-to-Carbohydrate Ratio}} = \text{Units of Insulin}$$

Correction dose: Blood glucose correction factor (insulin sensitivity factor) = _____ Target blood glucose = _____ mg/dL

Correction Dose Calculation Example

$$\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Correction Factor}} = \text{Units of Insulin}$$

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose _____ to _____ mg/dL, give _____ units Blood glucose _____ to _____ mg/dL, give _____ units

Blood glucose _____ to _____ mg/dL, give _____ units Blood glucose _____ to _____ mg/dL, give _____ units

See the worksheet examples in Advanced Insulin Management: Using Insulin-to-Carb Ratios and Correction Factors for instructions on how to compute the insulin dose using a student's insulin-to-carb ratio and insulin correction factor.

When to give insulin:

Breakfast

- ☐ Carbohydrate coverage only
- ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- ☐ Other: _____

Lunch

- ☐ Carbohydrate coverage only
- ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- ☐ Other: _____

Snack

- ☐ No coverage for snack
- ☐ Carbohydrate coverage only
- ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- ☐ Correction dose only: For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.
- ☐ Other: _____

Insulin therapy (continued)

Fixed Insulin Therapy Name of insulin: _____

- ☐ _____ Units of insulin given pre-breakfast daily
- ☐ _____ Units of insulin given pre-lunch daily
- ☐ _____ Units of insulin given pre-snack daily
- ☐ Other: _____

Parents/Guardians Authorization to Adjust Insulin Dose

- ☐ Yes ☐ No Parents/guardians authorization should be obtained before administering a correction dose.
- ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: \pm _____ units of insulin.
- ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, \pm _____ grams of carbohydrate.
- ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: \pm _____ units of insulin.

Student's self-care insulin administration skills:

- ☐ Independently calculates and gives own injections.
- ☐ May calculate/give own injections with supervision.
- ☐ Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.
- ☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

Additional information for student with insulin pump

Brand/model of pump: _____ Type of insulin in pump: _____

Basal rates during school: Time: _____ Basal rate: _____ Time: _____ Basal rate: _____
Time: _____ Basal rate: _____ Time: _____ Basal rate: _____
Time: _____ Basal rate: _____

Other pump instructions: _____

Type of infusion set: _____

Appropriate infusion site(s): _____

- ☐ For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.
- ☐ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.
- ☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Physical Activity

- May disconnect from pump for sports activities: ☐ Yes, for _____ hours ☐ No
- Set a temporary basal rate: ☐ Yes, _____% temporary basal for _____ hours ☐ No
- Suspend pump use: ☐ Yes, for _____ hours ☐ No

Additional information for student with insulin pump (continued)

Student's Self-care Pump Skills	Independent?	
Counts carbohydrates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates correct amount of insulin for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Administers correction bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes batteries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnects pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnects pump to infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepares reservoir, pod, and/or tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inserts infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoots alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other diabetes medications

Name: _____ Dose: _____ Route: _____ Times given: _____

Name: _____ Dose: _____ Route: _____ Times given: _____

Meal plan

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		____ to ____
Mid-morning snack		____ to ____
Lunch		____ to ____
Mid-afternoon snack		____ to ____

Other times to give snacks and content/amount: _____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): _____

Special event/party food permitted: ☐ Parents'/Guardians' discretion ☐ Student discretion

Student's self-care nutrition skills:

☐ Independently counts carbohydrates

☐ May count carbohydrates with supervision

☐ Requires school nurse/trained diabetes personnel to count carbohydrates

Physical activity and sports

A quick-acting source of glucose such as ☐ glucose tabs and/or ☐ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat ☐ 15 grams ☐ 30 grams of carbohydrate ☐ other: _____

☐ before ☐ every 30 minutes during ☐ every 60 minutes during ☐ after vigorous physical activity ☐ other: _____

If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

(See Administer Insulin for additional information for students on insulin pumps.)

Disaster plan

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follows (e.g., dinner and nighttime): _____

☐ Other: _____

Supplies to be kept at School

Blood glucose meter, blood glucose test strips, batteries for meter

Lancet device, lancets, gloves, etc.

Urine ketone strips

Insulin pump and supplies

Insulin pen, pen needles, insulin cartridges

Fast-acting source of glucose

Carbohydrate containing snack

Glucagon emergency kit

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 (student) _____ 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 contact my child's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian

Date

Student's Parent/Guardian

Date

School Nurse/Other Qualified Health Care Personnel

Date



KINGSWAY REGIONAL SCHOOL DISTRICT

Committed to Excellence

Mrs. Megan Anastasia, RN, BSN, CSN
7th & 8th, ext. 3022

Mrs. Kate Richards, RN, BSN, CPN, CSN
9th & 10th, ext. 4221

Mrs. Barbara Neal, RN, BSN, CSN
11th & 12th, ext. 4216

Middle School Fax (856) 467-5968

High School Fax (856) 467-4136

Indemnification/Hold Harmless Agreement for Pupil Self-Administration of Medication

We, the parents/guardians of _____
(Pupil Name)

hereby acknowledge and agree that the Kingsway Regional High School District shall incur no liability as a result of any injury arising from the self-administration of medication by

(Pupil Name)

We further agree that, pursuant of N.J.S.A. 18A:40-12.3(d), we shall indemnify, hold harmless and defend the Kingsway Regional High School District, its employees and agents, from and against any and all costs, expenses (including reasonable counsel fees), liabilities, judgements, losses, damages, suits, actions, fines, penalties, claims or demands of any kind and asserted by or on behalf of any person or entity arising out of or in any way connected with the

self-administration of medication by _____
(Pupil Name)

Parent/Guardian Signature

Date

Home of the Dragons