Georgia Cyber Academy
1745 Phoenix Boulevard; Suite #100
Atlanta, Georgia 30349
Fax: 14047959097
Email: 504@georgiacyber.org

DIABETES MEDICAL ACTION PLAN 2023-2024

Student Information		
Student's Name:	Date of Birth:	Grade:
Allergies:		
Medications Taken:		
Contact Information		
Mother's Name:	Home #:	Cell #:
Father's Name:	Home #:	Cell #:
Home Address:	City/State:	Zip Code:
Emergency Contact/Relationship:	Home #:	Cell #:
Primary Care Physician/Pediatrician:	Phone #:	Fax #:
Endocrinologist:	Phone #:	Fax #:
I understand that it is my responsibility as the parent/guardian of _____ to notify the 504 Coordinator/school personnel of any changes in my child's health condition and/or medication/treatment regimen. I authorize my child's physician and his/her staff to release the following information regarding my child's health condition. I understand that this health information will **only** be shared with pertinent school staff.		
Parent/Guardian Signature:	Date:	
Diabetes Information		
Type of Diabetes:		
Has the student been hospitalized in the last year? **Yes** **No**		
If yes, when?		
How will this impairment impact school attendance?		
Has the student been hospitalized within the last year for diabetes? **Yes** **No**		

If yes, when?

How will the student's diagnosis impact **virtual** school attendance?

Current Insulin Regimen

AM:	Type; Dose; Time
Lunch:	Type; Dose; Time
Dinner:	Type; Dose; Time
Bedtime:	Type; Dose; Time

Does the student require insulin during the school day? **Yes** **No**

Can the student administer insulin without adult assistance? **Yes** **No**

Pump Information:

Blood Glucose Monitoring

Target range of blood glucose is: _____mg/dl to _____ mg/dl

Can the student test his/her own blood glucose level? **Yes** **No**

Routine blood glucose testing times

Breakfast @ _____ a.m.	Lunch @ _____ a.m./p.m.
Dinner @ _____ p.m.	Bedtime @ _____ p.m.

Does student require supplemental blood glucose testing times?

Before exercise? **Yes** **No**	After exercise? **Yes** **No**
Before snack? **Yes** **No**	With symptoms of high or low? **Yes** **No**

Other:

Dietary Guidelines

Estimated total calories per day:

Meals/Snack Times

Breakfast @ _____ a.m.	Snack @ _____ a.m.
Lunch @ _____ p.m.	Snack @ _____ p.m.
Dinner @ _____ p.m.	Bedtime @ _____ p.m.

Will the student need to be reminded to take a snack for school events? **Yes** **No**
(Parent will provide snacks and water.)

Physical Activity

Does the student have restrictions regarding physical activity? **Yes** **No**

Describe exercise/sports limitations:

Is a snack required before physical activity? **Yes** **No**

Snack given before physical activity if:

Exercise should be delayed or avoided if the blood sugar is higher than _____ mg/dl and lower than _____ mg/dl.

Insulin Administration	
Insulin delivery system: ☐ **Syringe** or ☐ **Pen** or ☐ **Pump**	
Insulin type: ☐ **Humalog** or ☐ **Novolog** or ☐ **Apidra**	
Meal Insulin: (Best if given right before eating. For small children, can give within 15-30 minutes of the first bite of food or right after meal)	
Insulin to Carbohydrate ratio:	
Breakfast: 1 unit per _____ grams carbohydrate	Lunch: 1 unit per_____ grams carbohydrate
Fixed dose per meal:	
Breakfast: Give _____units/Eat _____grams of carbohydrates	Lunch: Give _____units/Eat _____grams of carbohydrates
Insulin Correction	
(For high blood sugar: Add before Meal Insulin to Correction Insulin for Total Insulin dose.)	
Use the following correction formula for pre-meal blood sugar over _____ (BG -_____) + _____ + extra units insulin to provide.	
Sliding Scale	
BG from _____ to _____ = _____ units	
BG from _____ to _____ = _____ units	
BG from _____ to _____ = _____ units	
BG from _____ to _____ = _____ units	
☐ _____ = _____ units	
☐ A snack will be provided each day at _____.	☐ No coverage for snack.
☐Carbohydrate coverage only for snack. (No BG check required)	
☐1 unit per _____ grams of carbohydrate	
☐ Fixed snack dose: Give _____ units/Eat _____ grams of carbohydrate.	
Parental Authorization to Adjust Insulin Dose	
Yes No Parents/Guardians are authorized to increase or decrease insulin-to-carb ratio within the following range: 1 unit per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate	
Yes No Parents/Guardians are authorized to increase or decrease correction dose with the following range: +/- _____ units of insulin	

Yes **No** Parents/Guardians are authorized to increase or decrease fixed insulin dose with the following range:

+/- _____ units of insulin.

Management of Low Blood Glucose

Mild Low Blood Sugar:	**Severe Low Blood Sugar:**
Alert and cooperative student (BG below _____) • Never leave student alone • Give 15 grams glucose; recheck in 15 minutes If BG remains below 70, retreat and recheck in 15 minutes • Notify parent if not resolved • If no meal is scheduled in the next hour, provide an additional snack with carbohydrate, fat, protein.	**Loss of consciousness or seizure** • Call 911. Open airway. Turn to side. • Glucagon injection IM/SubQ _____ or 0.50mg • Notify parent. • For students using insulin pump, stop pump by placing in "suspend" or stop mode, disconnecting at pigtail or clip, and/or removing an attached pump. If pump was removed, send with EMS to hospital.

Management of High Blood Glucose (Above _____ mg/dl)

- Sugar-free fluids/frequent bathroom privileges.
- If BG is greater than 300 and it's been 2 hours since last dose, give ☐ **HALF** ☐ **FULL** correction formula noted above.
- If BG is greater than 300 and it's been 4 hours since the last dose, give the FULL correction formula noted above.
- If BG is greater than _____, check for ketones. Notify parent if ketones are present.
- Child should be allowed to stay in school unless vomiting with moderate or large ketones present.

Management During Physical Activity

Student shall have easy access to fast-acting carbohydrates, snacks, and blood glucose monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below _____ mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

- Check blood sugar right before physical education to determine need for additional snack.
- If BG is less than _____ mg/dl, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.
- Student may disconnect insulin pump for 1 hour or decrease basal rate by _____.
- For new activities: Check blood sugar before and after exercise only until a pattern for management is established.
- A snack is required prior to participation in physical education.

Signature of Authorized Prescriber (MD, NP, PA)	Date:
Student's Name:	Date of Birth:

Notify Parent of the following conditions: (if unable to reach parent, call diabetes provider office.)

a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon.

b. Blood sugars in excess of 300 mg/dl, when ketones present.

c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

Special Management of Insulin Pump

- Contact Parent in event of:
  - Pump alarms or malfunctions
  - Detachment of dressing / infusion set out of place
  - Leakage of insulin
  - Student must give insulin injection
  - Student has to change site
  - Soreness or redness at site
  - Corrective measures do not return blood glucose to target range within _____ hrs.

- Parents will provide extra supplies including infusion sets, reservoirs, batteries, pump insulin, and syringes.

This student requires assistance by the School Nurse or Trained Diabetes Personnel with the following aspects of diabetes management:

- ☐ Monitor and record blood glucose levels
- ☐ Respond to elevated or low blood glucose levels
- ☐ Administer glucagon when required
- ☐ Calculate and give insulin Injections
- ☐ Administer oral medication
- ☐ Monitor blood or urine ketones
- ☐ Follow instructions regarding meals and snacks
- ☐ Follow instructions as related to physical activity
- ☐ Respond to CGM alarms by checking blood glucose with glucose meter.
- ☐ Treat using Management plan on page
- ☐ Insulin pump management: administer insulin, inspect infusion site, contact parent for problems.
- ☐ Provide other specified assistance:

_____

This student may independently perform the following aspects of diabetes management:

Monitor blood glucose:

- ☐ In the classroom
- ☐ In any area of school and at any school related event

- ☐ Monitor urine or blood ketones
- ☐ Calculate and give own injections
- ☐ Calculate and give own injections with supervision
- ☐ Treat hypoglycemia (low blood sugar)
- ☐ Treat hyperglycemia (elevated blood sugar)
- ☐ Carry supplies for blood glucose monitoring
- ☐ Carry supplies for insulin administration
- ☐ Determine own snack/meal content
- ☐ Manage insulin pump
- ☐ Replace insulin pump infusion set
- ☐ Manage CGM

Location of Supplies/Equipment (Parent will provide and restock all supplies, snacks and low sugar treatment supplies.)

Blood glucose equipment:	☐ with school personnel	☐ with parent	☐ with student
Insulin Admin Supplies:	☐ with school personnel	☐ with parent	☐ with student
Ketone Supplies:	☐ with school personnel	☐ with parent	☐ with student
Glucagon kit:	☐ with school personnel	☐ with parent	☐ with student
Glucose gel:	☐ with school personnel	☐ with parent	☐ with student
Juice/low blood glucose:	☐ with school personnel	☐ with parent	☐ with student
Snacks:	☐ with school personnel	☐ with parent	☐ with student

Signatures

My signature provides authorization for the above Diabetes Mellitus Medical Management Plan. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

Signature of Prescriber (Authorized Prescriber: MD, NP, PA):	Date:
Name of Authorized Prescriber:	
NPI License #:	Phone #:
Address:	
Fax #:	Date:

I, (Parent/Guardian) _____ understand that all treatments and procedures may be performed by the student and/or Trained Diabetes Personnel within the school, or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by Georgia state law.	
Signature of Parent/Guardian:	Date: