



Safe at School

Diabetes Medical Management Plan

SCHOOL YEAR: _____



STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____

TABLE OF CONTENTS		
PARENT/GUARDIAN SECTIONS	PAGE	SECTION
Demographics	1	1
Supplies/Disaster Plan/Field	1	2
Trips Self-Management Skills	2	3
Student Recognition of Highs/Lows	2	4
Glucose Monitoring at School	2	5
Parent Approval Signature	6	9
DIABETES PROVIDER SECTIONS	PAGE	SECTION
Insulin Doses at School	3	6
Dosing Table (Single Page Update)	4	6A
Correction Sliding Scale	4	6B
Long Acting Insulin Other Medications	4	6C
Other Medications	4	6D
Low Glucose Prevention	5	7
Low Glucose Management	5	8
High Glucose Management	6	9
Approval Signatures	6	9

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): <input type="checkbox"/> Foot/Bicycle <input type="checkbox"/> Car <input type="checkbox"/> Bus <input type="checkbox"/> Attends Before School Program	Meals Times: <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Pre Dismissal Snack	Physical Activity: <input type="checkbox"/> Gym <input type="checkbox"/> Recess <input type="checkbox"/> Sports <input type="checkbox"/> Additional information:	Travels to: <input type="checkbox"/> Home <input type="checkbox"/> After School Program Via: <input type="checkbox"/> Foot/Bicycle <input type="checkbox"/> Car <input type="checkbox"/> Student Driver <input type="checkbox"/> Bus
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Parent/Guardian #1 (contact first): _____ Relationship: _____ Parent/Guardian #2: _____ Relationship: _____

Cell #: _____ Home #: _____ Work #: _____ Cell #: _____ Home #: _____ Work #: _____

E-mail Address: _____ E-mail Address: _____

Indicate preferred contact method: _____ Indicate preferred contact method: _____

2. NECESSARY SUPPLIES / DISASTER PLANNING / EXTENDED FIELD TRIPS

- 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.

<ul style="list-style-type: none"> • Insulin • Syringe/Pen Needles • Ketone Strips • Treatment for lows and snacks • Glucagon • Antiseptic Wipes • Blood Glucose (BG) 	<ul style="list-style-type: none"> • Meter with (test strips, lancets, extra battery) – required for all Continuous Glucose Monitor (CGM) users • Pump Supplies (Infusion Set, 	<ul style="list-style-type: none"> • Cartridge, extra Battery/Charging Cord) if applicable • Additional supplies:
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- View Disaster/Emergency Planning details – refer to Safe at School Guide
- Please review expiration dates and quantities monthly and replace items prior to expiration dates
- 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	CGM <input type="checkbox"/> (Requires Calibration)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate Counting		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin Administration:	Syringe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can Calculate Insulin Doses		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glucose Management:	Low Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	High Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Section 1-5 completed by Parent/Guardian

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/dL DEFAULT)

Name of Health Care Provider/Clinic: _____

Contact #: _____

Fax #: _____

Email Address (non-essential communication): _____

Other: _____

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		<input type="checkbox"/> PE/Activity Day Dose
			<input type="checkbox"/> Use Formula	<input type="checkbox"/> See Sliding Scale 6B	
Select if dosing is required for meal	<input type="checkbox"/> Carbohydrate Ratio: Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	<input type="checkbox"/> Fixed Meal Dose	Formula: (Pre-Meal Glucose Reading minus Target Glucose) divided by Correction Factor = Correction Dose <input type="checkbox"/> May give Correction dose every _____ hours as needed (DEFAULT 3 hours)		Adjust: <input type="checkbox"/> Carbohydrate Dose <input type="checkbox"/> Total Dose Indicate dose instructions below:
<input type="checkbox"/> Breakfast	Breakfast Carb Ratio = _____ g/unit	Breakfast units	<input type="checkbox"/> Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	<input type="checkbox"/> No Correction dose	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
<input type="checkbox"/> AM Snack	AM Snack Carb Ratio = _____ g/unit	AM Snack units	<input type="checkbox"/> Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	<input type="checkbox"/> No Correction dose	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
	<input type="checkbox"/> No Carb Dose <input type="checkbox"/> No Insulin if < _____ grams		<input type="checkbox"/> No Correction dose		
<input type="checkbox"/> Lunch	Lunch Carb Ratio = _____ g/unit	Lunch units	<input type="checkbox"/> Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	<input type="checkbox"/> No Correction dose	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
<input type="checkbox"/> PM Snack	PM Snack Carb Ratio = _____ g/unit	PM Snack units	<input type="checkbox"/> Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	<input type="checkbox"/> No Correction dose	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
	<input type="checkbox"/> No Carb Dose <input type="checkbox"/> No Insulin if < _____ grams		<input type="checkbox"/> No Correction dose		
<input type="checkbox"/> Dinner	Dinner Carb Ratio = _____ g/unit	Dinner units	<input type="checkbox"/> Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	<input type="checkbox"/> No Correction dose	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
			<input type="checkbox"/> No Correction dose		

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	<input type="checkbox"/> Lantus, Basaglar, Toujeo (Glargine) <input type="checkbox"/> Levemir (Detemir) <input type="checkbox"/> Tresiba (Degludec) <input type="checkbox"/> Other	units	<input type="checkbox"/> Daily Dose <input type="checkbox"/> Overnight Field Trip Dose <input type="checkbox"/> Disaster/Emergency Dose	Subcutaneously
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6D. OTHER MEDICATIONS

Time	<input type="checkbox"/> Metformin <input type="checkbox"/> Other	units	<input type="checkbox"/> Daily Dose <input type="checkbox"/> Overnight Field Trip Dose <input type="checkbox"/> Disaster/Emergency Dose	Route
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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

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

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: _____