Children's Physician Group
DIABETES MEDICAL MANAGEMENT PLAN
School Year:

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Other emergency contact: _____ Phone #: _____ Relationship: _____

Insurance Carrier: _____ Preferred Hospital: _____

BLOOD GLUCOSE (BG) MONITORING:

☑ Before meals ☑ as needed for suspected low/high BG ☐ 2 hours after correction
☐ Midmorning ☐ Mid-afternoon ☐ Before dismissal
☐ May use Continuous Glucose Monitor (CGM) in place of finger stick blood sugar monitoring.

INSULIN ADMINISTRATION:

Insulin delivery system: ❑ Syringe or ❑ Pen or ❑ Pump **Insulin type:** ❑Humalog or ❑Novolog or ❑Apidra or ❑Admelog ❑Fiasp

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 carbohydrate
Lunch: Give ___ units/Eat ____ grams of carbohydrate

CORRECTION INSULIN: (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

SNACK: ☐ A snack will be provided each day at: _____
Carbohydrate coverage only for snack (**No BG check required**):
☐ No coverage for snack
☐ **1** unit per _____ grams of carb
☐ Fixed snack dose: Give ___ units/Eat ____ grams of carb

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 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.
☐ If CGM alarms/reads under LOW LIMIT after 15 minutes of treating a low, student should verify BG with finger stick.

SEVERE low sugar: Loss of consciousness or seizure
☑ Call 911. Open airway. Turn to side.
☑ Glucagon injection IM/SubQ ❑ _____ ☑ 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 last dose, give **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.
☐ If the CGM alarms/reads over HIGH LIMIT, student may give correction bolus according to above instructions

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): _____ Phone_____ Date: _____

Student's Name: _____ Date of Birth: _____

NOTIFY PARENT of the following conditions: (If unable to reach parent, call diabetes provider office at _____)

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.

SPECIAL MANAGEMENT CONTINUOUS GLUCOSE MONITORS (CGM): _____ (Brand of CGM)

☐ Contact Parent in event of: issue with alarms or malfunctions

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 (as instructed on page 1)
☑ 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. Check BG with glucose meter if symptoms do NOT match sensor readings. Treat using Management Plan on page 1.
☐ 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 the designated clinic office
- ❑ 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
❑ Carry prescription medication listed in the school DMMP
❑ Determine own snack/meal content
❑ Manage insulin pump
❑ Replace insulin pump infusion set
❑ Management of CGM (Calibrating, monitoring, and responding to alarms)
❑ Cell phone is use as CGM receiver

LOCATION OF SUPPLIES/EQUIPMENT: (Parent will provide and restock all supplies, snacks and low blood sugar treatment supplies.)
This section will be completed by school personnel and parent:

	Clinic room	With student		Clinic room	With student
Blood glucose equipment	❑	❑	Glucagon kit	❑	❑
Insulin administration supplies	❑	❑	Glucose gel	❑	❑
Ketone supplies	❑	❑	Juice /low blood glucose snacks	❑	❑

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 AUTHORIZED PRESCRIBER: _____ DATE: _____
Authorized Prescriber: MD, NP, PA

Name of Authorized Prescriber:

Address:

Phone:

SIGNATURES

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.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____

Student's Name: _____ Date of Birth: _____