DIABETES MANAGEMENT CARE PLAN

Learner Name_____ **Date of birth**___/___/_____

Allergies_____ **School**_____ **Grade / Teacher**_____

Date of Diagnosis _____ **Preferred Hospital** _____

LEARNER SCHEDULE

Arrival time: _____ Dismissal Time: _____

Travels to school by: _____ Travels from school by: _____

Breakfast	AM Snack	Lunch/Recess	PM or pre-dismissal Snack	GYM	Other:

RESPONSIBILITIES

LEARNER	PARENT
• Carry diabetic bag/kit with supplies: CGM (Continuous Glucose Monitor) &/or glucose meter, alcohol wipes, lancets, needles, insulin, glucagon, fast acting carbs, extra snacks & protein. • Finger poke as needed with clean hands. • Self-advocate needs. • Report symptoms to staff immediately. • Throw garbage away. • Put needles in sharps container. • Follow staff instruction and direction.	• Communicate plan changes with the school nurse. • Check expiration dates & restock learners bag/kit as needed. • Provide supplies (3 days minimum) as necessary: CGM &/or glucose meter, alcohol wipes, lancets, needles, insulin, pump supplies, glucagon, fast acting carbs, extra snacks & protein. • Ensure all devices are charged, calibrated, and in working order before school.

LEARNER SKILLS

	Full Support	Supervision	Independent
Glucose Testing: ☐ Meter ☐ CGM Brand_____ Pin _____			
Troubleshooting alarms - high / lows			
Manage rapid trends in glucose rate – rise/fall			
Counting Carbs			
Calculates Insulin Dosage			
Insulin Administration: ☐ Pen ☐ Pump ☐ Other _____ Pin _____			
Smart Phone: ☐ Yes ☐ NO Pin _____			
Other:			

Full Support: All care will be performed by the school nurse or trained diabetes school designee.
Supervision: School Nurse or designee will supervise &/or assist learner as needed. Independence is encouraged.
Independent: Learner will manage diabetes independently or with support upon request and as needed.

BLOOD GLUCOSE TESTING

Target Range of blood glucose _____mg/dl to _____mg/dl

Check all that apply:

☐ Before Breakfast ☐ Before AM Snack

☐ Before Lunch ☐ Before PM snack

☐ Before PE ☐ After PE

☐ Before Dismissal ☐ Other:

☐ 2 hours after correction dose ☐ As needed for signs/symptoms of illness or high/low blood glucose

Preferred testing site: ☐ Fingertip ☐ CGM ☐ Other:

Preferred testing location(s): ☐ Classroom ☐ Nurse office ☐ Other:

Continuous glucose monitor (CGM)

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

☐ CGM is remotely monitored by parent/guardian. A written communication plan may be required to minimize interruptions for the learner, teacher, school nurse, or designee.

☐ CGM may be used for monitoring, treatment, insulin dosing unless symptoms do not match reading.

Note:

- Learners will have access to devices and school wi-fi for viewing & monitoring as needed.
- Learner will confirm CGM results with fingertip blood glucose if signs or symptoms of hypoglycemia.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape or Coban.
- If CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- CGM calibration is required by parents &/or independent learners as needed.
- Refer to the manufacturer's instructions on how to use the learner's device.

Finger stick if:

* Glucose reading is below _____ (default 80mg/dl) or above _____ (default 300mg/dl)
* If CGM is still reading below 70mg/dL 15mins following a low treatment.
* CGM malfunction, dislodged, or no sensor reading.
* CGM reading does not match signs/symptoms or is inconsistent.
* CGM does not show both numbers and arrows.

Notify Parent/Guardian if glucose is below _____ (default 55mg/dl) or above _____ (default 300mg/dl)

Other instructions: _____

_____

INSULIN ADMINISTRATION

Insulin Device

☐ Syringe ☐ Insulin Pen ☐ Smart Pen* ☐ Pump* (brand & model) _____

* Dosing determined by pump/bolus calculator unless device failure (see below).

Insulin Type

Fast Acting: ☐ Novolog(aspart) ☐ Humalog(lispro) ☐ Apidra(glulisine) ☐ Other:
Give at school? ☐ Yes ☐ No

Long Acting ☐ Lantus ☐ Levemir ☐ Tresiba ☐ Other:
Give at school? ☐ Yes ☐ No

Diet: ☐ Normal ☐ Restricted _____ Special event food permitted ☐Yes ☐ NO

Insulin Delivery / Timing

☐ Prior to Meal (Important in maintaining good glucose control). ☐ Pre-bolus ____ minutes before eating.

*Carbohydrate substitution will be provided if learner does not complete the meal.

☐ After Meal (As soon as possible within 30 minutes)

☐ Partial Dose (preferred if unpredictable eating patterns or refusal to eat)

□ Give _____ grams of carbohydrates prior to the meal with remainder following the meal.

□ May advance to prior to meal when learner demonstrates consistent eating.

Insulin Therapy (complete if dosing is required at school)

Meal	**Fixed dose**	**Meal Dose (Carbohydrate Ratio)** Total meal carbs divided by carb ratio = insulin dose	**Correction Dose** ☐ Formula* ☐ see sliding scale below *(Actual glucose – Target glucose) divided by correction factor = insulin dose
Breakfast	___ unit	Ratio = ___ grams/unit	Target glucose ____mg/dL Correction factor ____mg/dL ☐ No correction if <3hrs from last correction dose.
AM Snack	___ unit	Ratio = ___ grams/unit No insulin if < ____ grams	Target glucose ____mg/dL Correction factor ____mg/dL ☐ No correction if <3hrs from last correction dose.
Lunch	___ unit	Ratio = ___ grams/unit	Target glucose ____mg/dL Correction factor ____mg/dL ☐ No correction if <3hrs from last correction dose.
PM Snack	___ unit	Ratio = ___ grams/unit No insulin if < ____ grams	Target glucose ____mg/dL Correction factor ____mg/dL ☐ No correction if <3hrs from last correction dose.
Other:	___ unit	Ratio = ___ grams/unit	Target glucose ____mg/dL Correction factor ____mg/dL ☐ No correction if <3hrs from last correction dose.

Sliding Scale: ☐ Meals only ☐ Meals and Snacks ☐Every ___ (default 3 hours) as needed

If blood glucose is:

_____ to _____mg/dL = _____units _____ to _____mg/dL = _____units
_____ to _____mg/dL = _____units _____ to _____mg/dL = _____units

_____ to _____mg/dL = _____units _____ to _____mg/dL = _____units

Additional instructions: _____

_____

HYPOGLYCEMIA (LOW BLOOD SUGAR)

Causes: Too much insulin, too little food, &/or increase in physical activity.

Symptoms: (Circle to tailor to learner)

Shakiness / trembling	Sweating	Excessive hunger	Dizziness
Irritability	Tired	Poor Coordination	Headache
Personality/mood changes	Weak	Confused / dazed appearance	Other:

Treatment:

Blood sugar below _____ (default 80mg/dl) &/or symptomatic requires immediate treatment.

1. Test blood glucose with finger poke.
2. Immediately give a 15g fast acting glucose (Circle to tailor to learner)

Juice/soda	Glucose tab/gel	Candy	Fruit snacks	Other:

3. Notify your school nurse or designee.
4. Suspend, stop, or disconnect insulin pump if necessary. (Keep pump with learner)
5. Stop activity until blood glucose is above ____ (default 80mg/dl). (See activity orders)
6. Recheck blood sugar after 10-15mins and repeat treatment until above 80mg/dl.

   Call parent/guardian? ☐ Yes ☐ No
7. If symptomatic or hypoglycemia requires multiple treatments a parent/guardian or emergency contact may be contacted to pick up their learner.

☐ Give mini dose ____ grams when low glucose is predicted, arrow down, or symptoms at ____ mg/dL.

☐ The school nurse may use clinical judgement and adjust amount as necessary to treat hypoglycemia.

Additional Treatment: _____

Note:

- The learner may be aware that their blood sugar is low, but this can occur with little warning.
- Frequently low blood sugar can occur before lunch or after strenuous exercise.
- The learner **must be accompanied by an adult** to the testing site (*i.e., Office*) if not feeling well.
- The learner's concentration and memory may be compromised. They may require a rest period of 20 minutes or longer to recover (all symptoms subsided and alert) before participating in activities or performing academically (*i.e., testing/quizzes).*

EMERGENCY

** If the learner is unable to eat or drink, is unresponsive or losing consciousness, or is having seizure/convulsion activity **GIVE EMERGENCY GLUCAGON IMMEDIATLEY AND CALL 911.** Call the school nurse and parent/guardian(s). Never give fluids/food as the learner could choke. **When in doubt CALL 911!**

MEDICATION: (check all that apply)

☐ Glucagon Emergency Kit Route ☐ IM ☐ SC/SQ Dose: ☐0.5mg or ☐1.0mg

☐ Baqsimi Nasal Glucagon 3mg ☐ Other:

HIGH BLOOD SUGAR (HYPERGLYCEMIA)

Causes: Not enough insulin, too much or wrong foods, illness, stress, decrease in physical activity, or pump failure.

Symptoms: (circle all that apply to learner)

Stomachache	Excessive thirst	Frequent urination
Nausea/vomiting	Blurry Vision	Fruity odor on the breath
Fatigue	Dry Skin	Other:

Treatment:

Blood sugar above _____ (default 300mg/dl) &/or symptomatic requires treatment.

1. Test blood glucose with finger poke.
2. Notify your School Nurse or designee.
3. Give 8-16 ounces of water or non-sugary drink if tolerated.
4. Provide bathroom access.
5. Allow light activity.
6. School Nurse or independent learner may administer insulin per physician orders.
7. For insulin pumps consider failure: Replace infusion set if possible &/or remove pump and use an insulin pen for insulin delivery.
8. If symptomatic or blood glucose remains over 300mg/dL for 1 hour with interventions a parent/guardian(s) or emergency contact may be contacted to pick up their learner.

EMERGENCY

* A high blood sugar does not need urgent care unless the learner becomes ill or shows signs of DKA (Diabetic Ketoacidosis) – vomiting, confusion, or ketones in their blood or urine. Call the parent/guardian(s) or emergency contacts. If severe call 911.

KETONES

Learners should arrive at school stable and with their blood glucose in a stable and controlled range (above 80mg/dL & below 300mg/dL). Ketones should be checked at home before the learner arrives at school whenever possible. If ketone monitoring is required at school a written plan with clear parameters, interventions, and evaluations to address the problem is necessary. The learner must independently urinate without the school nurse's help unless a written toilet accommodation plan is on file. *See the hyperglycemia section for interventions to lower blood glucose at school.

Check: ☐ Urine Ketones ☐ Blood Ketones

Treatment directions: _____

_____

_____

Disaster Plan

* The learner should always carry their diabetic bag/kit with them. In the event of a disaster or extended field trip, the school nurse or designee will take diabetic supplies and medication to the learners' location if needed and provide diabetic care as outlined in this plan.

SPORTS AND PHYSICAL ACTIVITY

Exercise is an important part of diabetes management and should be encouraged. PE teachers and coaches should be familiar with the symptoms and treatment of low blood sugar and have a 15g fast-acting source of glucose available at the site of physical activities. Learners should **NOT** exercise if blood glucose is below ____ (default 80mg/dL) or above ____ (default 350mg/dL).

☐ Give ____ grams if blood glucose is below____mg/dL before physical activity.

☐ Start activity mode _____minutes before activity begins and stop _____minutes after activity ends.

☐ Learner is independently able to start/stop activity mode.

☐ Learner is NOT independently able to start/stop activity mode. Independence is encouraged.

Additional Treatment:_____

_____

I authorize the school nurse or designated personnel to contact the prescriber as needed to obtain or clarify health information and share information outlined in this "Diabetes Management Care Plan" with individuals working within the school who need to know for the purpose of providing first aid or other specific emergency care as described in this plan. I approve and request school personnel to follow the above plan in an emergency involving my child. I agree to notify the school immediately if my child's health status changes, or there is a change or cancellation of this "Diabetes Management Care Plan." I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the learners' health record.

Furthermore, by signing I understand I can revoke this authorization at any time in writing and agree to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of diabetic cares and/or treatments to the above-named learner from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused, or claimed to be caused or to result from care in accord with the above "Diabetes Management Care Plan".

Parent/Guardian Name_____

Phone: (H)_____ **(C)**_____ **(W)**_____

Alternate Contact Name_____

Phone: (H)_____ **(C)**_____ **(W)**_____

Parent /Guardian Signature X_____ **Date**_____

This Diabetic Management Care Plan has been approved by:

Provider Name_____ **Location**_____

Phone_____ **Fax**_____

Provider Signature X_____ **Date**_____

Office use:

Acknowledged / reviewed by: _____ Date_____

Office:_____ Cell:_____