DAILY DIABETES CARE PLAN
SCHOOL YEAR: _____

Student Name:	**DOB:**
School:	**Student ID:**
MOTHER:	**FATHER:**
HOME:	**HOME:**
WORK:	**WORK:**
CELL:	**CELL:**
If parents cannot be reached call:	
Name:	**Phone:**
Name:	**Phone:**
Physician: **Phone:**	**Hospital Preference:**

BASIC INFORMATION AND STUDENT HISTORY: Type I diabetes is a condition in which the pancreas no longer makes insulin, a hormone required to regulate blood sugar.

SCHOOL MANAGEMENT: This daily plan is based on the Diabetes Medical Management Plan (DMMP) provided by the physician. **Please refer to the DMMP when providing diabetes care.**

1. **MEALS EATEN AT SCHOOL:** ☐ breakfast ☐ lunch ☐ am snack ☐ pm snack
2. **BLOOD GLUCOSE MONITORING:** ☐Student is independent ☐ Student is not independent
   - BG should be checked in ☐ clinic ☐ classroom ☐ other _____
     - ☐ before breakfast @ _____
     - ☐ before lunch @ _____
     - ☐ before PE @ _____
     - ☐ after PE@ _____
     - ☐ for symptoms of low or high blood sugar
     - ☐ before dismissal @ _____
     - ☐ Student has a continuous glucose monitor (Dexcom) _____
3. **INSULIN ADMINISTRATION:** ☐ Student is independent ☐ Student is not independent
   - Insulin will be administered in ☐ clinic ☐ classroom ☐ other _____
   - Insulin administration supplies are kept: ☐ in clinic ☐ in classroom ☐ with student
   - Insulin is administered with: ☐ breakfast ☐ lunch ☐ am snack ☐ pm snack
4. **PE:** ☐ Keep _____ (fast-acting carbohydrate) with student during exercise.
   ☐ Student should not participate in PE/exercise if BG is < _____ or > than _____
5. **Classroom Treatment of Low Blood Sugar:**
   ☐ Watch for signs of low blood sugar: student feels low and/or is pale, sweaty, fast heart beat, shaky, irritable, dizzy, anxious, hungry, blurry vision, weakness, fatigue, _____
   ☐ If student feels/looks low, check blood sugar if possible and follow DMMP. If unable to check blood sugar, treat with _____(fast acting carbohydrate) and send to clinic with adult or call for clinic worker and follow DMMP.
6. **Other:**
   - Allow student to provide diabetes care in classroom/other areas ☐ Yes ☐ No
   - A staff member with appropriate training should accompany student on all field trips
   - _____

CALL PARENT: if any questions regarding diabetes care, for blood sugar > 300 and ketones present, if the student's schedule changes (i.e. field day, field trips, testing), and as instructed on the DMMP.
CALL 911: if student has a severe low blood sugar (loss of consciousness, seizure, unable to swallow, and glucagon has been given) or if student has a blood sugar over 300 with vomiting and you are unable to contact parent.

_____ _____

PARENT SIGNATURE / DATE COUNTY SCHOOL NURSE SIGNATURE / DATE

Confidentiality must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential.

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: (Treat BG below _____ mg/dl or above _____mg/dl as outlined below.)

- ☑ Before meals
- ☐ Midmorning
- ☑ as needed for suspected low/high BG
- ☐ Mid-afternoon
- ☐ 2 hours after correction
- ☐ Before dismissal

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 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.

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.

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: _____ page 1 of 2

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 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
- ☐ 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 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/GAURDIAN SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____

INFORMATION FOR SCHOOL MANAGEMENT OF DIABETES MELLITUS
School Year: _____

Student's Name: _____ Date of Birth: _____ Effective Date: _____

School Name: _____ STUDENT ID: _____Grade**:** _____

CONTACT INFORMATION:

Parent/Guardian #1: _____Phone #: Home: _____Work: _____ Cell/Pager: _____

Parent/Guardian #1: _____Phone #: Home: _____Work: _____ Cell/Pager: _____

Diabetes Care Provider: _____Phone #: _____

Other emergency contact: _____ Relationship: _____

Phone Numbers: Home: _____ Cellular/Pager: _____

Insurance Carrier: _____ Preferred Hospital: _____

EMERGENCY NOTIFICATION: Notify parents of the following conditions:

a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering Glucagon.
b. Blood sugars in excess of 300 mg/dl. With ketones present
c. Positive urine ketones.
d. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness

STUDENT'S COMPETENCE WITH PROCEDURES: (Must be verified by parent and school nurse)

Blood glucose monitoring
Determining insulin dose
Measuring insulin
Injecting insulin
Determine own snack/meal content
Carry supplies for BG monitoring
Carry supplies for insulin administration
Monitor BG in classroom
Self treatment for mild low blood sugar
Independently operates insulin pump

MEAL PLAN:

	Time	Location	CHO Content	Time	Location	CHO Content
Bkft	_____	_____	_____	Mid-PM	_____	_____	_____
Mid-AM	_____	_____	_____	Before PE	_____	_____	_____
Lunch	_____	_____	_____	After PE:	_____	_____	_____

Meal/snack will be considered mandatory. Times of meals/snacks will be at routine school times unless alteration is indicated. School nurse will contact diabetes care provider for adjustment in meal times. Content of meal/snack will be determined by: Student Parent School nurse Diabetes provider

Please provide school cafeteria with a copy of this meal plan order to fulfill USDA requirements. Parent to provide and restock snacks and low blood sugar supplies box.

LOCATION OF SUPPLIES/EQUIPMENT: (To be completed by school personnel)

Blood glucose equipment: Clinic/health room With student
Insulin administration supplies: Clinic/health room With student
Glucagon emergency kit: _____ **Glucose gel**: _____ **Ketone testing supplies**: _____
Fast acting carbohydrate: Clinic/health room With student **Snacks**: Clinic/health room With student

SIGNATURES: I understand that all treatments and procedures may be performed by the student and/or unlicensed 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 form will assist the school in developing a health plan and in providing appropriate care for my child.

PARENT SIGNATURE: _____ DATE: _____

COUNTY SCHOOL NURSE SIGNATURE: _____ DATE: _____

Authorization for Student to Carry a Prescription Inhaler, EpiPen® or Insulin

_____ _____ needs to carry the following prescription labeled inhaler, EpiPen® or insulin with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication. (It is preferable that a second prescription labeled inhaler, EpiPen® or additional insulin be kept in the clinic in case the first is lost or left at home.)

_____

Medicat n Dosage and Directions

_____

Physician's Signature or Stam Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of use of my medication in case I start having problems.

_____

Student's Signature Date

I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen; the privilege of carrying the medication may be revoked. I release the school district and its employees of any legal responsibility when the above named student administers his/her own medication.

_____

Parent/Guardian Signature Date