

**DIABETES Care**

Child's picture  
Face only

*This packet MUST be completed, signed, and ATTACHED to a Diabetes Medical Action Plan (MAP). Please download, complete the packet and return to the main office.*

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2024-2025 school year.

**\*Your child's health care provider will choose to either use their own MAP template, OR the Diabetes MAP template within this packet.\***

**CONTACT INFORMATION**

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

**PARENT/GUARDIAN CONSENT**

I, (parent/guardian), \_\_\_\_\_, request that my child, \_\_\_\_\_, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Bus # \_\_\_\_\_  
 Driver: \_\_\_\_\_  
 Route # \_\_\_\_\_  
 Medical File \_\_\_\_\_  
 Transportation Office Use ONLY if needed



Student Name: \_\_\_\_\_ This Plan expires June 30, 20\_\_

### School-based Medical Management Plan for the Student with Diabetes Mellitus

#### To be completed by Parent/Guardian

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Diabetes Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

#### To be completed by Diabetes Team

Date of Diabetes Diagnosis: \_\_\_\_\_  Type 1  Type 2  Other: \_\_\_\_\_

#### SECTION I - Routine Management

##### Glucose Levels:

Monitoring method:  Continuous glucose monitor (CGM) Type \_\_\_\_\_ **OR**  Finger Stick

Preferred location:  Classroom  Office  Where convenient

Glucose check performed by:  Student, Independently  Student, Supervised **OR**  Designated School Personnel

Check prior to:  Breakfast  Snack  Lunch  Before PE/Recess  Before leaving school

Ensure that glucose level is above 100 before physical activity or boarding the bus  Other: \_\_\_\_\_

Always:  Check when symptomatic  Perform finger stick if symptoms do not match CGM values

❖ If glucose level is low (< \_\_\_\_\_ or < \_\_\_\_\_ with symptoms), see Section III, Low Glucose Level (Hypoglycemia)

❖ If glucose level is high (> \_\_\_\_\_), see Section IV, High Glucose Level (Hyperglycemia)

##### Insulin Administration: (Type of Insulin per Medication Administration Authorization Form, see Section II)

Preferred administration location:  Classroom  Office  Where convenient

Pen/Syringe - Dosing per:  Card  Chart  Scale  InPen\*  PUMP\* \*All settings pre-programmed by parent

**Breakfast:**  Prior to  Immediately after **Lunch:**  Prior to  Immediately after **Snack (carb coverage only):**  Prior to  NA  Immediately after

Insulin dosage calculated by:  Student, Independently  Student, Supervised **OR**  Designated School Personnel

Student will determine all carb counts independently **OR**  Family will provide carb counts to school staff daily

For foods provided by school nutrition services, school staff will ensure student/family has access to carb counts

Insulin administered by:  Student, Independently  Student, Supervised **OR**  Designated School Personnel

##### Adjustments to Insulin Dosing:

Parents/Guardians have sufficient training and experience and are authorized by the prescriber to submit written requests to Designated School Personnel for insulin dosing adjustments within the following parameters:

Yes  No Adjust correction/sensitivity factor within the following range: 1 unit: \_\_\_\_\_ to 1 unit: \_\_\_\_\_ (Target Glucose: \_\_\_\_\_)

Yes  No Adjust insulin-to-carbohydrate ratio within the following range: 1 unit: \_\_\_\_\_ to 1 unit: \_\_\_\_\_

Yes  No Increase or decrease fixed insulin dose within the following range: +/- \_\_\_\_\_ units of insulin.

Designated School Personnel should contact provider if parents request insulin dosing adjustments > \_\_\_\_\_ times/week.

**Written communication between Provider & Parent** (e.g. emails, clinic visit summary, etc.) may be used to adjust insulin dosing until updated Insulin Dosing Tool is received by the Designated School Personnel.



Student Name: \_\_\_\_\_

This Plan expires June 30, 20\_\_

**SECTION II – Medication Administration Authorization (MAA) Form**

This form must be completed fully in order for schools to administer the required medication. The school nurse (RN) will call the prescriber, as allowed by HIPAA, if questions arise about the student’s medications and/or related diabetes care.

**Prescriber’s Authorization:**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

1. Medication Name: Insulin:  Admelog  Humalog/Lispro  Novolog/Aspart  Apidra  Fiasp

Dose: Per Accompanying Insulin Dosing Tool

Route:  Pen/Syringe (Insulin dosing per  card  chart  scale InPen)

PUMP (All settings pre-programmed into pump by parent)

InPen (All settings pre-programmed into app by parent)

Time: Breakfast:  Prior to  Immediately after

Lunch:  Prior to  Immediately after

Snack:  Prior to  Immediately after

Potential Side Effects: \_\_\_\_\_

Student may self-carry insulin:  Yes  No Student may self-administer insulin:  Yes  No

2. Medication Name: Glucagon

Route & Dose:  Injection, Glucagon/Glucagen/Gvoke PFS:  0.5 mg  
 1.0 mg

Auto-Injection, Gvoke HypoPen:  0.5mg/0.1mL

1mg/0.2mL

Nasal, Baqsimi Glucagon Nasal Powder:  3mg

Time: When severe low glucose levels are suspected as indicated by unconsciousness, seizure, or extreme disorientation with inability to safely swallow oral quick-acting glucose.

Potential Side Effects: Nausea, Vomiting, Rebound Hyperglycemia, Other: \_\_\_\_\_

Student may self-carry Glucagon:  Yes  No

Please see attached supplemental MAA Form for additional medication orders. Additional training provided by a RN, PA, physician, or Certified Diabetes Educator to Designated School Personnel is required.

Prescriber’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(No stamped signatures, please)

Print Name/Title: \_\_\_\_\_ NPI#: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

**Parent/Guardian Authorization:**

I request Designated School Personnel to administer the medications as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medications at school. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by RN, PA, Physician, or Certified Diabetes Educator providing training to Designated School Personnel:

Signature/Title

Date

**SECTION III - Responding to a Low Glucose Level (Hypoglycemia)**

Below are common symptoms that may be observed when glucose levels are **low**.

Reminder: These symptoms can change and some students may not display any symptoms.

Parents **may** choose to circle their child's most common symptoms.

<b>Symptoms of a Low Glucose Level (Hypoglycemia)</b>	
Shaky   Weak   Sweaty   Rapid heartbeat   Dizzy   Hungry   Headache   Lack of coordination   Seizure   Tiredness Loss of consciousness   Pale   Confusion   Irritability/Personality changes   Continuous Glucose Monitor (CGM) alarm/arrows Other: _____	
<b>Actions for Treating Hypoglycemia</b>	
Treatment for Mild to Moderate Hypoglycemia	Treatment for Severe Hypoglycemia
<p><b>Notify School Nurse or Designated School Personnel as soon as you observe symptoms.</b>            If possible, check glucose level via finger stick.</p> <p><b>Do NOT send student to office alone!</b></p> <p>Treat for hypoglycemia if glucose level is:  <input type="checkbox"/> less than _____ or less than _____ with symptoms.</p> <p><b>WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.</b></p>	<p><b>Student is:</b></p> <ul style="list-style-type: none"> <li>✓ <b>Unconscious</b></li> <li>✓ <b>Having a seizure</b></li> <li>✓ <b>Having difficulty swallowing</b></li> </ul> <p><b>Follow Emergency Steps</b></p> <ol style="list-style-type: none"> <li><b>1. Administer Glucagon</b></li> <li><b>2. Call 9-1-1</b></li> <li><b>3. Activate MERT (Medical Emergency Response Team)</b></li> </ol>
"Rule of 15"	Administer Glucagon
<ul style="list-style-type: none"> <li><input type="checkbox"/> Treat with <b>15 grams of quick-acting glucose</b> (4 oz. juice or 3-4 glucose tabs)</li> </ul> <p style="text-align: center;"><b>OR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Treat with <b>30 grams of quick-acting glucose</b> (8 oz. juice or 6-8 glucose tabs) <b>if glucose level is less than _____</b></li> <li><input type="checkbox"/> Wait 15 minutes. Recheck glucose level.</li> <li><input type="checkbox"/> Repeat quick-acting glucose treatment if glucose level is less than _____ mg/dL.</li> <li><input type="checkbox"/> Contact the student's parents/guardians.</li> </ul> <p><b>Then:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> If an hour or more before next meal, give a snack of protein and complex carbohydrates</li> <li><input type="checkbox"/> If mealtime and no difficulty swallowing, monitor and allow student to eat lunch while waiting to recheck glucose level.</li> <li><input type="checkbox"/> Once glucose level is greater than _____ and student has finished eating lunch, give insulin to <b><u>cover meal carbs only.</u></b></li> </ul>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Stay with student, protect from injury, turn on side</li> <li><input checked="" type="checkbox"/> Do not put anything into the student's mouth</li> <li><input type="checkbox"/> Suspend or remove insulin pump (if worn)</li> <li><input checked="" type="checkbox"/> Administer Glucagon Per MAA Form:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Injection, Glucagon/Glucagen/Gvoke PFS:                   <ul style="list-style-type: none"> <li><input type="checkbox"/> 0.5 mg</li> <li><input type="checkbox"/> 1.0 mg</li> </ul> </li> <li><input type="checkbox"/> Auto-Injection, Gvoke HypoPen:                   <ul style="list-style-type: none"> <li><input type="checkbox"/> 0.5mg/0.1ml</li> <li><input type="checkbox"/> 1mg/0.2ml</li> </ul> </li> <li><input type="checkbox"/> Nasal, Baqsimi Glucagon Nasal Powder:                   <ul style="list-style-type: none"> <li><input type="checkbox"/> 3mg</li> </ul> </li> </ul> </li> <li><input type="checkbox"/> Implement Medical Emergency Response:               <ul style="list-style-type: none"> <li>✓ Take AED and any emergency medical supplies to location;</li> <li>✓ Inform Central Administration of Emergency;</li> <li>✓ Contact parents; Meet them in the parking lot;</li> <li>✓ Meet the ambulance/direct traffic;</li> <li>✓ Provide copy of student medical record to EMS;</li> <li>✓ Control the scene;</li> <li>✓ Document emergency and response on Emergency Response/Incident Report form;</li> <li>✓ Conduct debriefing session of incident and response following the event.</li> </ul> </li> </ul>

**SECTION IV - Responding to High Glucose Levels (Hyperglycemia)**

Below are common symptoms that may be observed when glucose levels are **high**.

Reminder: These symptoms can change and some students may not display any symptoms.

Parents **may** choose to circle their child's most common symptoms.

<b>Symptoms of a High Glucose Level (Hyperglycemia)</b>	
Increased thirst    Increased urination    Tiredness    Increased appetite    Decreased appetite    Blurred Vision    Headache Sweet, fruity breath    Dry, itchy skin    Achiness    Stomach pain/nausea/vomiting    Seizure    Loss of consciousness/coma Continuous Glucose Monitor (CGM) alarm/arrows    Other: _____	
<b>Actions for Treating Hyperglycemia</b>	
Treatment for Hyperglycemia	Treatment for Hyperglycemia Emergency
<p><b>Notify School Nurse or Designated School Personnel as soon as you observe symptoms.</b></p> <p><input type="checkbox"/> <b>For glucose level less than 300:</b></p> <ul style="list-style-type: none"> <li>✓ If not mealtime – do not give correction dose of insulin, offer water, return to normal routine if feeling well</li> <li>✓ If mealtime, give insulin as prescribed (see Section I, Routine Management, Insulin Administration)</li> </ul> <p><input type="checkbox"/> <b>For glucose level 300 or greater:</b></p> <ul style="list-style-type: none"> <li>✓ If mealtime, give insulin as prescribed (see Section I, Routine Management, Insulin Administration)</li> <li>✓ Have student check ketones</li> </ul> <p><input type="checkbox"/> <b>Positive Ketones:</b></p> <ul style="list-style-type: none"> <li>✓ Call parent/guardian               <ul style="list-style-type: none"> <li>▪ Trace or Small - attempt to flush, remain in school if feeling well and no vomiting</li> <li>▪ Moderate or Large - parent pick-up immediately</li> </ul> </li> <li>✓ Give 8-16 oz. of water hourly</li> <li>✓ No exercise, physical education, or recess</li> <li>✓ Recheck ketones at next urination</li> <li>✓ If on pump, check infusion set/pump site:               <ul style="list-style-type: none"> <li>▪ Is tubing disconnected?</li> <li>▪ Is there wetness around the pump site, etc.?</li> </ul> </li> </ul> <p><input type="checkbox"/> <b>Negative Ketones:</b></p> <ul style="list-style-type: none"> <li>✓ If not mealtime - offer water, return to normal routine if feeling well</li> </ul> <p><input type="checkbox"/> <b>If no ketone strips are available:</b></p> <ul style="list-style-type: none"> <li>✓ Treat as Positive Ketones</li> <li>✓ Request strips from family</li> </ul>	<p><b>Call 9-1-1 Activate Medical Emergency Response</b></p> <p><input type="checkbox"/> Call 9-1-1 if severe symptoms are present. Severe symptoms <b>may</b> include:</p> <ul style="list-style-type: none"> <li>✓ Abdominal pain</li> <li>✓ Nausea/Repetitive Vomiting</li> <li>✓ Change in level of consciousness</li> <li>✓ Lethargy</li> </ul> <p><input type="checkbox"/> Implement Medical Emergency Response:</p> <ul style="list-style-type: none"> <li>✓ Take AED and any emergency medical supplies to location;</li> <li>✓ Inform Central Administration of Emergency;</li> <li>✓ Contact parents; Meet them in the parking lot;</li> <li>✓ Meet the ambulance/direct traffic;</li> <li>✓ Provide copy of student medical record to EMS;</li> <li>✓ Control the scene;</li> <li>✓ Document emergency and response on Emergency Response/Incident Report form;</li> <li>✓ Conduct debriefing session of incident and response following the event.</li> </ul>

Parent/Guardian Signature  
(Void if not signed)

Date

Physician Signature

Date



Student Name: \_\_\_\_\_

This Plan expires June 30, 20\_\_

**To be completed by Trainer of Student-specific School Health (SSH) Team in collaboration with all SSH Team members.**

**SECTION IV - Food and Miscellaneous**

- Snack daily at: \_\_\_\_\_  Snack as needed for low glucose level  Allow unlimited access to food
- Allow unlimited access to water or bathroom  Have 15 grams of quick-acting glucose available at site of physical activity
- For special occasions that involve food:  always contact parent for guidance **OR**  student can self-manage
- Out of classroom, student will travel with:  buddy  adult
  - always **OR**  when support is requested or is obviously needed
- Fieldtrips - Student will be accompanied by trained school personnel, unless parent volunteers to attend (parent attendance not required)
- Plan for access to food and appropriate support during School Emergencies developed/implemented
- Record all care provided/send documentation home:  Weekly  When requested by parent  Other: \_\_\_\_\_

**Location of Glucagon (Glucagon/Gvoke/Baqsimi):**  In Office  In Classroom  With Student  Other: \_\_\_\_\_

**Location of Other Diabetes Supplies (see attached list):**  In Office  In Classroom  With Student  Other: \_\_\_\_\_

School Name: \_\_\_\_\_ Principal: \_\_\_\_\_

School Address: \_\_\_\_\_

**SSH Team consists of:**

Parent, Student, Designated School Personnel

**AND**

RN, Physician, PA, or Certified Diabetes Educator (Trainer)

**The following Designated School Personnel have received training to support implementation of this plan:**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Title**

**Training provided by:**

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date