

**HUMBOLDT COUNTY SCHOOL DISTRICT
DIABETES MEDICAL MANAGEMENT PLAN**



Student: _____ **DOB:** _____

Date of Plan: _____ **Type of Diabetes:** Type 1 Type 2 Pre-Diabetes

Dependent: Requires school staff supervision and assistance for diabetes management.

Independent: Manages diabetes independently; school staff will contact parents/emergency services if needed.

BLOOD GLUCOSE (BG) TESTING

Target Range: _____ mg/dl to _____ mg/dl

Test BG: Symptomatic Before meals Before exercise Other: _____

No exercise if BG < _____ mg/dl or > _____ mg/dl

Continuous Glucose Monitor (CGM): Yes No If yes, type: Dexcom G6 FreeStyle Libre Other:

 Use CGM for treatment if BG is between _____ - _____ mg/dl and asymptomatic. Otherwise, confirm with a finger stick.

HYPOGLYCEMIA (LOW BG) TREATMENT

If BG < _____ mg/dl or symptomatic:

- Administer **15g fast-acting carbs**
- Recheck BG in **15 minutes**
- If BG < _____ mg/dl, repeat treatment
- Return to class if BG is in target range and symptoms resolve
- Provide a **protein snack** if no meal is scheduled within 30 minutes
- If BG remains low after **3 cycles**, parent pickup required
- **Call 911** if student is unconscious, unresponsive, or having a seizure

Glucagon Ordered? Yes No

Baqsimi 3mg intranasally Gvoke 0.5mg subcutaneously Gvoke 1 mg subcutaneously

Call **911** and parents if Glucagon is administered

HYPERGLYCEMIA (HIGH BG) TREATMENT

If BG > _____ mg/dl:

- Administer insulin per correction dose orders
- Encourage **water intake** and allow bathroom access

- Contact parents if BG remains over _____ mg/dl for _____ minutes and student will be required to be picked up by family

Individual Orders: _____

INSULIN ADMINISTRATION

Insulin-to-Carb Ratio (I:C): _____ unit per _____ grams of carbs
Correction Dose: _____ unit per _____ mg/dl for BG above _____ mg/dl

Insulin Type: Aprida Humalog Novolog Other: _____
Delivery Method: Syringe Insulin Pen Insulin Pump (Type: _____)
Administer insulin at: Breakfast Snack Lunch Other: _____

Pump Guidelines:

- If pump fails, administer insulin per I:C ratio by injection and contact family
 - **Basal Rate:** _____ units/hour at specified times
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HEALTHCARE PROVIDER INFORMATION

Provider Name: _____
Address: _____
Phone: _____ **Fax:** _____
Signature: _____ **Date:** _____
NPI #: _____

PARENT/GUARDIAN CONSENT

- Parents must supply **medications, snacks, and equipment**
- Immediate **pickup required** if supplies are missing
- Parent/guardian authorizes school staff to **assist with diabetes care**
- School staff may **exchange information** with healthcare provider
- **Hold harmless agreement:** The school is not liable for assisting with diabetes management

Parent/Guardian Signature: _____
Date: _____

CARBOHYDRATE & MENU INFORMATION

- School meals: Carbohydrates based on current menus (subject to change)
- Parents must provide **carb counts** for home-packed meals

Per Nevada Revised Statutes: this order can only be signed by a MD/DO, nurse practitioner, or certified physician's assistant, is only valid for one calendar year, and must be updated upon change in medical condition..