



**Safe at School**

# Diabetes Medical Management Plan

SCHOOL YEAR:

(Add student photo here.)

STUDENT LAST NAME:  FIRST NAME:  DOB:

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**PARENTS/GUARDIANS: Please complete pages 1 and 2 of this form and approve the final plan on page 6.**

## 1. DEMOGRAPHIC INFORMATION—PARENT/GUARDIAN TO COMPLETE

Student First Name:  Last Name:  DOB:  Student's Cell #:  Diabetes Type:  Date Diagnosed: Month:  Year:

School Name:  School Phone #:  School Fax #:  Grade:

Home Room:  School Point of Contact:  Contact Phone #:

**STUDENT'S SCHEDULE** Arrival Time:  Dismissal Time:

Travels to school by (check all that apply): <input type="checkbox"/> Foot/Bicycle <input type="checkbox"/> Car <input type="checkbox"/> Bus <input type="checkbox"/> Attends Before School Program	Meals Times: <input type="checkbox"/> Breakfast <input type="text"/> <input type="checkbox"/> AM Snack <input type="text"/> <input type="checkbox"/> Lunch <input type="text"/> <input type="checkbox"/> PM Snack <input type="text"/> <input type="checkbox"/> Pre Dismissal Snack <input type="text"/>	Physical Activity: <input type="checkbox"/> Gym <input type="checkbox"/> Recess <input type="checkbox"/> Sports <input type="checkbox"/> Additional information: <input type="text"/>	Travels to: <input type="checkbox"/> Home <input type="checkbox"/> After School Program Via: <input type="checkbox"/> Foot/Bicycle <input type="checkbox"/> Car <input type="checkbox"/> Student Driver <input type="checkbox"/> Bus
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Parent/Guardian #1 (contact first):  Relationship:  Parent/Guardian #2:  Relationship:

Cell #:  Home #:  Work #:  Cell #:  Home #:  Work #:

E-mail Address:  E-mail Address:

Indicate preferred contact method:  Indicate preferred contact method:

## 2. NECESSARY SUPPLIES / DISASTER PLANNING / EXTENDED FIELD TRIPS

1. A 3-day minimum of the following Diabetes Management Supplies should be provided by the parent/guardian and accessible for the care of the student at all times.

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Insulin</li> <li>• Syringe/Pen Needles</li> <li>• Ketone Strips</li> <li>• Treatment for lows and snacks</li> <li>• Glucagon</li> <li>• Antiseptic Wipes</li> <li>• Blood Glucose (BG)</li> </ul> | <ul style="list-style-type: none"> <li>• Meter with (test strips, lancets, extra battery) - required for all Continuous Glucose Monitor (CGM) users</li> <li>• Pump Supplies (Infusion Set,</li> </ul> | <ul style="list-style-type: none"> <li>• Cartridge, extra Battery/Charging Cord) if applicable</li> <li>• Additional supplies:</li> </ul> <input type="text"/> |
|--|--|--|

View Disaster/Emergency Planning details – refer to Safe at School Guide

2. Please review expiration dates and quantities monthly and replace items prior to expiration dates.

3. In the event of a disaster or extended field trip, a school nurse or other designated personnel will take student's diabetes supplies and medications to student's location.

Name of Health Care Provider/Clinic:  Contact #:  Fax #:

Email Address (non-essential communication):  Other:

STUDENT LAST NAME:  FIRST NAME:  DOB:

**3. SELF-MANAGEMENT SKILLS (DEFINITIONS BELOW)**

	Full Support	Supervision	Self-Care
Glucose Monitoring: Meter <input type="checkbox"/> CGM <input type="checkbox"/> (Requires Calibration)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate Counting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin Administration: Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Pump <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can Calculate Insulin Doses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glucose Management: Low Glucose <input type="checkbox"/> High Glucose <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Carry Diabetes Supplies: <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify items: <input type="text"/>			
Smart Phone: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			

Device Independence:  CGM  Interpretation & Alarm Management  Sensor Insertion  Calibration  Insulin Pumps  Bolus  Connects/Disconnects  Temp Basal Adjustment  Interpretation & Alarm Management  Site Insertion  Cartridge Change

Full Support: All care performed by school nurse and trained staff (as permitted by state law).

Supervision: Trained staff to assist & supervise. Guide & encourage independence.

Self-Care: Manages diabetes independently. Support is provided upon request and as needed.

**4. STUDENT RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CHECK ALL THAT APPLY)**

**Symptoms of High:**

Thirsty  Frequent Urination  Fatigued/Tired/Drowsy  Headache  Blurred Vision   
Warm/Dry/Flushed Skin  Abdominal Discomfort  Nausea/Vomiting  Fruity Breath  Unaware  Other:

**Symptoms of Low:**

None  Hungry  Shaky  Pale  Sweaty  Tired/Sleepy  Tearful/Crying  Dizzy Irritable  
 Unable to Concentrate  Confusion  Personality Changes  Other:

Has student lost consciousness, experienced a seizure or required Glucagon:  Yes  No If yes, date of last event:

Has student been admitted for DKA after diagnosis:  Yes  No If yes, date of last event:

**5. GLUCOSE MONITORING AT SCHOOL**

**Monitor Glucose:**

Before Meals  With Physical Complaints/Illness (include ketone testing)  High or Low Glucose Symptoms  
 Before Exams  Before Physical Activity  After Physical Activity  Before Leaving School  Other:

**CONTINUOUS GLUCOSE MONITORING (CGM)**

(Specify Brand & Model: )

Specify Viewing Equipment:  Device Reader  Smart Phone  
 Insulin Pump  Smart Watch  iPod/iPad/Tablet

CGM is remotely monitored by parent/guardian.  
Document individualized communication plan in Section 504 or other plan to minimize interruptions for the student.  
 May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

**CGM Alarms:**


Low alarm  mg/dL

High alarm  mg/dL if applicable

**Please:**

- Permit student access to viewing device at all times
- Permit access to School Wi-Fi for sensor data collection and data sharing
- Do not discard transmitter if sensor falls

**Perform finger stick if:**

- Glucose reading is below  mg/dL or above  mg/dL
- If CGM is still reading below  mg/dL (DEFAULT 70 mg/dL) 15 minutes following low treatment
- CGM sensor is dislodged or sensor reading is unavailable.  (see CGM addenda for more information)
- Sensor readings are inconsistent or in the presence of alerts/alarms
- Dexcom does not have both a number and arrow present
- Libre displays Check Blood Glucose Symbol
- Using Medtronic system with Guardian sensor

**Notify parent/guardian if glucose is:**

below  mg/dL (<55 mg/dL DEFAULT)

Section 1-5 completed by Parent/Guardian

Name of Health Care Provider/Clinic:

Email Address (non-essential communication):

Contact #:

Other:

Fax #:

STUDENT LAST NAME:  FIRST NAME:  DOB:

**6. INSULIN DOSES AT SCHOOL - HEALTHCARE PROVIDER TO COMPLETE**

**Insulin Administered Via:**

- Syringe
- Insulin Pen ( Whole Units  Half Units)
- i-Port
- Smart Pen
- Other
- Insulin Pump (Specify Brand & Model: )
- Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device
- Insulin Pump is using DIY Looping Technology (child/parent manages device independently, nurse will assist with all other diabetes management)

**DOSING** to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 6A).

**Insulin Administration Guidelines**

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with students that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when student does not complete their meal.

- Prior to Meal** (DEFAULT)
- After Meal** as soon as possible and within 30 minutes
- Snacking** avoid snacking  hours (DEFAULT 2 hours) before and after meals

**Partial Dose Prior to Meal:** (preferred for unpredictable eating patterns using insulin pump therapy)

- Calculate meal dose using  grams of carbohydrate prior to the meal
- Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)
- May advance to Prior to Meal when student demonstrates consistent eating patterns.

**For Injections, Calculate Insulin Dose To The Nearest:**

- Half Unit (round down for < 0.25 or < 0.75 and round up for ≥ 0.25 or ≥ 0.75)
- Whole Unit (round down for < 0.5 and round up for ≥ 0.5)

**Supplemental Insulin Orders:**

- Check for **KETONES** before administering insulin dose if BG >  mg/dL (DEFAULT >300 mg/dL or >250 mg/dL on insulin pump) or if student complains of physical symptoms. Refer to section 9. for high blood glucose management information.
- Parents/guardians are authorized to adjust insulin dose +/- units  Insulin dose +/-  units
  - Insulin dose +/-  %
- Insulin to Carb Ratio +/-  grams/units
  - Insulin Factor +/-  mg/dL/unit

Additional guidance on parent adjustments:

Name of Health Care Provider/Clinic:  Contact #:  Fax #:   
Email Address (non-essential communication):  Other:

STUDENT LAST NAME:  FIRST NAME:  DOB:

**6A. DOSING TABLE—HEALTHCARE PROVIDER TO COMPLETE – SINGLE PAGE UPDATE ORDER FORM**

Insulin: (administered for food and/or correction)

**Rapid Acting Insulin:**  Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine)  Other:

**Ultra Rapid Acting Insulin:**  Fiasp (Aspart)  Lyumjev (Lispro-aabc)  Other:

**Other insulin:**  Humulin R  Novolin R

Meal & Times	Food Dose		Glucose Correction Dose <input type="checkbox"/> Use Formula <input type="checkbox"/> See Sliding Scale 6B	<input type="checkbox"/> PE/Activity Day Dose
Select if dosing is required for meal	<input type="checkbox"/> <b>Carbohydrate Ratio:</b> Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	<input type="checkbox"/> <b>Fixed Meal Dose</b>	<b>Formula:</b> (Pre-Meal Glucose Reading minus <b>Target Glucose</b> ) divided by <b>Correction Factor</b> = Correction Dose <input type="checkbox"/> May give Correction dose every <input type="text"/> hours as needed (DEFAULT 3 hours)	<b>Adjust:</b> <input type="checkbox"/> <b>Carbohydrate Dose</b> <input type="checkbox"/> <b>Total Dose</b> Indicate dose instructions below:
<input type="checkbox"/> <b>Breakfast</b>	Breakfast Carb Ratio = <input type="text"/> g/unit	<b>Breakfast</b> <input type="text"/> units	<input type="checkbox"/> <b>Target Glucose is:</b> <input type="text"/> mg/dL & <b>Correction Factor is:</b> <input type="text"/> mg/dL/unit <input type="checkbox"/> <b>No Correction dose</b>	Carb Ratio <input type="text"/> g/unit Subtract <input type="text"/> % Subtract <input type="text"/> units
<input type="checkbox"/> <b>AM Snack</b>	AM Snack Carb Ratio = <input type="text"/> g/unit <input type="checkbox"/> No Carb Dose <input type="checkbox"/> No Insulin if < <input type="text"/> grams	<b>AM Snack</b> <input type="text"/> units	<input type="checkbox"/> <b>Target Glucose is:</b> <input type="text"/> mg/dL & <b>Correction Factor is:</b> <input type="text"/> mg/dL/unit <input type="checkbox"/> <b>No Correction dose</b>	Carb Ratio <input type="text"/> g/unit Subtract <input type="text"/> % Subtract <input type="text"/> units
<input type="checkbox"/> <b>Lunch</b>	Lunch Carb Ratio = <input type="text"/> g/unit	<b>Lunch</b> <input type="text"/> units	<input type="checkbox"/> <b>Target Glucose is:</b> <input type="text"/> mg/dL & <b>Correction Factor is:</b> <input type="text"/> mg/dL/unit <input type="checkbox"/> <b>No Correction dose</b>	Carb Ratio <input type="text"/> g/unit Subtract <input type="text"/> % Subtract <input type="text"/> units
<input type="checkbox"/> <b>PM Snack</b>	PM Snack Carb Ratio = <input type="text"/> g/unit <input type="checkbox"/> No Carb Dose <input type="checkbox"/> No Insulin if < <input type="text"/> grams	<b>PM Snack</b> <input type="text"/> units	<input type="checkbox"/> <b>Target Glucose is:</b> <input type="text"/> mg/dL & <b>Correction Factor is:</b> <input type="text"/> mg/dL/unit <input type="checkbox"/> <b>No Correction dose</b>	Carb Ratio <input type="text"/> g/unit Subtract <input type="text"/> % Subtract <input type="text"/> units
<input type="checkbox"/> <b>Dinner</b>	Dinner Carb Ratio = <input type="text"/> g/unit	<b>Dinner</b> <input type="text"/> units	<input type="checkbox"/> <b>Target Glucose is:</b> <input type="text"/> mg/dL & <b>Correction Factor is:</b> <input type="text"/> mg/dL/unit <input type="checkbox"/> <b>No Correction dose</b>	Carb Ratio <input type="text"/> g/unit Subtract <input type="text"/> % Subtract <input type="text"/> units

**6B. CORRECTION SLIDING SCALE**

Meals Only  Meals and Snacks  Every  hours as needed

to  mg/dL =  units     to  mg/dL =  units     to  mg/dL =  units  
 to  mg/dL =  units     to  mg/dL =  units     to  mg/dL =  units  
 to  mg/dL =  units     to  mg/dL =  units     to  mg/dL =  units

**6C. LONG ACTING INSULIN**

<input type="text"/> Time	<input type="checkbox"/> Lantus, Basaglar, Toujeo (Glargine) <input type="checkbox"/> Levemir (Detemir) <input type="checkbox"/> Tresiba (Degludec) <input type="checkbox"/> Other <input type="text"/>	<input type="text"/> units	<input type="checkbox"/> Daily Dose <input type="checkbox"/> Overnight Field Trip Dose <input type="checkbox"/> Disaster/Emergency Dose	Subcutaneously
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**6D. OTHER MEDICATIONS**

<input type="text"/> Time	<input type="checkbox"/> Metformin <input type="checkbox"/> Other <input type="text"/>	<input type="text"/> units	<input type="checkbox"/> Daily Dose <input type="checkbox"/> Overnight Field Trip Dose <input type="checkbox"/> Disaster/Emergency Dose	Route <input type="text"/>
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Signature is required here if sending ONLY this one-page dosing update.

Diabetes Provider Signature:

Date:

Name of Health Care Provider/Clinic:  Contact #:  Fax #:

Email Address (non-essential communication):  Other:

STUDENT LAST NAME:  FIRST NAME:  DOB:

## 7. LOW GLUCOSE PREVENTION (HYPOGLYCEMIA)

### Allow Early Interventions

- Allow Mini-Dosing of carbohydrate (i.e., 1-2 glucose tablets) when low glucose is predicted, sensor readings are dropping (down arrow) at  mg/dL (DEFAULT 80 mg/dL or 120 mg/dL prior to exercise) or with symptoms.
- Allow student to carry and consume snacks  School staff to administer
- Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (DEFAULT)

### Insulin Management (Insulin Pumps)

**Temporary Basal Rate** Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia.

- Pre-programmed Temporary Basal Rate Named  (Omnipod)
- Temp Target (Medtronic)  Exercise Activity Setting (Tandem)  Activity Feature (Omnipod 5)

**Start:**  minutes prior to exercise for  minutes duration (DEFAULT 1 hour prior, during, and 2 hours following exercise).

**Initiated by:**  Student  Trained School Staff  School Nurse

- May disconnect and suspend insulin pump up to  minutes (DEFAULT 60 minutes) to avoid hypoglycemia, personal injury with certain physical activities or damage to the device (keep in a cool and clean location away from direct sunlight).

**Exercise (Exercise is a very important part of diabetes management and should always be encouraged and facilitated).**

### Exercise Glucose Monitoring

- prior to exercise  every 30 minutes during extended exercise  following exercise  with symptoms

**Delay exercise if glucose is <  mg/dL (120 mg/dL**

### DEFAULT) Pre-Exercise Routine

- Fixed Snack:** Provide  grams of carbohydrate prior to physical activity if glucose <  mg/dL
- Added Carbs:** If glucose is <  mg/dL (120 DEFAULT) give  grams of carbohydrates (15 DEFAULT)
- TEMPORARY BASAL RATE as indicated above**

**Encourage and provide access to water for hydration, carbohydrates to treat/prevent hypoglycemia, and bathroom privileges during physical activity**

## 8. LOW GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Low Glucose below  mg/dL (below 70 mg/dL DEFAULT) or below  mg/dL before/during exercise (DEFAULT is < 120 mg/dL).

1. If student is awake and able to swallow give  grams of fast acting carbohydrate (DEFAULT 15 grams). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.  
 School nurse/parent may change amount given
2. Check blood glucose every 15 minutes and re-treat until glucose >  mg/dL (DEFAULT is 80 mg/dL or 120 mg/dL before exercise).

### SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)

Administer Glucagon, position student on their side and monitor for vomiting, call 911 and notify parent/guardian. If BG meter is available, confirm hypoglycemia via BG fingerstick. Do not delay treatment if meter is not immediately available. If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with student.

- Glucagon Emergency Kit 1mg/mL by:  IM Injection 0.5 mg OR  1 mg
- Gvoke PFS (prefilled syringe) by SC Injection  0.5 mg  1.0 mg
- Gvoke HypoPen (auto-injector) by SC Injection  0.5 mg  1.0 mg
- Gvoke Kit (ready to use vial and syringe, 1mg/0.2 ml) by SC injection
- Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector  Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe
- Baqsimi Nasal Glucagon 3 mg

Name of Health Care Provider/Clinic:  Contact #:  Fax #:

Email Address (non-essential communication):  Other:

STUDENT LAST NAME:  FIRST NAME:  DOB:

**9. HIGH GLUCOSE MANAGEMENT (HYPERGLYCEMIA)**

Management of High Glucose over \_\_\_\_\_ mg/dL (Default is 300 mg/dL OR 250 mg/dl if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 30 minutes. May consume fluids in classroom. Allow frequent bathroom privileges.
2. Check for Ketones (before giving insulin correction)
  - a. If Trace or Small Urine Ketones (0.1 - 0.5 mmol/L if measured in blood)
    - Consider insulin correction dose. Refer to the "Correction Dose" Section 6.A-B. for designated times correction insulin may be given.
    - *Can return to class and PE unless symptomatic*
    - Recheck glucose and ketones in 2 hours
  - b. If Moderate or Large Urine Ketones (0.6 - 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.
    - Contact parents/guardian or, if unavailable, healthcare provider
    - **Administer correction dose via injection.** If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the "Blood Glucose Correction Dose" Section 6.A-B
    - If using insulin pump change infusion site/cartridge or use injections until dismissal.
    - No physical activity until ketones have cleared
    - Report nausea, vomiting, and abdominal pain to parent/guardian to take student home.
    - Call 911 if changes in mental status and labored breathing are present and notify parents/guardians.

Send student's diabetes log to Health Care Provider (include details): If pre-meal blood glucose is below 70 mg/dL or above 240 mg/dL more than 3 times per week or you have any other concerns.

**Parents / Legal Guardians Please Read Carefully: By signing below, I understand and agree to the following:**

- An Individualized Healthcare Plan (IHP) will be developed for students who have a health condition that necessitates an IHP.
- the school district and its employees and agents are not liable for an injury arising from a student's self-monitoring or self-administration of medication.
- the parent or guardian indemnifies and holds harmless the district and its employees and agents against a claim arising from a student's self-monitoring or self-administration of medication.
- The school district and its employees and agents are not liable for an injury arising from the administration of medication authorized by an IHP.
- the parent or guardian shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication authorized by an IHP.
- I give permission for my child to be given the above medication as prescribed while at school per BCSD policies.
- I give permission for information about this medication and/or my child's health to be exchanged between the BCSD school nurse or designated BCSD employee and/or the Health Care Provider, the pharmacist who filled this prescription, and/or their designee.
- I further give permission for information about my child to be shared with persons who legitimately need to know for the safety and well-being of my child.
- I agree to allow student's medication to travel with teacher/staff on field trips if medication time occurs during field trip.
- I agree to follow the BCSD policies concerning medications.
- I agree that it is my responsibility to provide the school with the medication for my child and any supplies needed.
- I agree that it is my responsibility to notify the school if my child's health and/or medication(s) change in any way.

**SIGNATURES**

**This Diabetes Medical Management Plan has been approved by:**

Student's Physician/Health Care Provider:  Date:

I, (parent/guardian)  give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school)  to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to collaborate with my child's physician/health care provider.

**Acknowledged and received by:**

Student's Parent/Guardian:  Date:

**Acknowledged and received by:**

School Nurse or Designee:  Date:

Name of Health Care Provider/Clinic:  Contact #:  Fax #:

Email Address (non-essential communication):  Other: