# Diabetes Medical Management Plan

**School District: _____ School: _____ School Year: _____**

***Shaded areas to be completed by Parent/Guardian and School Nurse***

**Student Name: _____ DOB: _____ ID#: _____**
**Grade: _____ Teacher/Homeroom: _____ Student's Phone: _____**
**Diagnosis: □ Type 1, ICD-10: _____ □ Type 2, ICD-10:_____ □ Other: _____, ICD-10:_____**

## Parent/Guardian Contact Information

| | |
|---|---|
| Parent/Guardian: _____ | Parent/Guardian: _____ |
| Phone: Cell_____ Work_____ | Phone: Cell_____ Work_____ |
| Email: _____ | Email: _____ |

## Provider Contact Information

Provider: _____ Practice Location: _____
Phone #: _____ Fax#: _____Email: _____

## School Schedule Information

Transportation to/from school: □ Bus □ Walk □ Car Before/After school program: _____
PE/Gym class day/time: _____ Recess schedule: _____
Meals at school: □ Breakfast, Time: _____ □ Lunch, Time: _____ □ Other, Time: _____

## Supplies: Checklist and Location

Supplies listed below prescribed by provider and to be *provided to school by parent/guardian*:

| | | |
|---|---|---|
| □ Insulin | □ CGM supplies | □ Treatment for lows and snacks |
| □ Syringe/Pen/Needles | □ Glucagon | □ DMMP (Diabetes Medical Management Plan) |
| □ Pump supplies | □ Ketone strips/meter | □ Other:_____ |
| □ Glucometer | | |

Student supplies' locations: _____
Student carries supplies: □Yes □ No Location (i.e.: waist pack, cross body bag, backpack, etc.):_____

## Blood Glucose Monitoring in School

**Blood Glucose Target Range: _____ to _____ mg/dL (Correct above _____ mg/dL)**

Glucose Monitoring: □ CGM (Continuous Glucose Monitor), Specify brand/model: _____
(See *Addendum B: Provider Orders for Continuous Glucose Monitor*, page 7)
□ Glucometer, Specify brand/model: _____

**Student will be permitted access to app/reader at all times; permit access to school Wi-Fi; do not discard transmitter if sensor fails*

**Monitoring schedule:**
□ Before breakfast, time: _____ □ Before lunch, time: _____ □ Before boarding bus, time: _____
□ Suspected hypo/hyperglycemia □ Feels unwell, requests testing □ Other: _____

**Student Monitoring and Management:**
□ Student can test and manage independently
(*Diabetes Self-Management Authorization Form* – or similar) signed; kept with student's records/DMMP)
□ Student needs supervision or assistance (circle one) with testing and management
□ Parent/Guardian will monitor student's CGM remotely and communicate with School Nurse and/or student
**Note: Remote monitoring is not the responsibility of school staff/school nurse. This will be determined by each school district.*

***Shaded areas to be completed by Parent/Guardian and School Nurse***

## Diabetes Medication at School:

Oral medications:
At Home:_____ At School: _____
Insulin at home:
- □ Rapid Acting Insulin: Humalog/Admelog (Lispro), Novolog (Aspart), or Apidra (Glulisine)
- □ Ultra Rapid Acting Insulin: Fiasp (Aspart) or Lyumjev (Lispro-aabc)
- □ Long Acting Insulin: Glargine, Lantus, Basaglar, Detemir/Levemir,Toujeo, Semglee, or Degludec
- □ Other: _____

Insulin* at School:
- □ Rapid Acting Insulin: Humalog/Admelog (Lispro), Novolog (Aspart), or Apidra (Glulisine)
- □ Ultra Rapid Acting Insulin: Fiasp (Aspart) or Lyumjev (Lispro-aabc)
- □ Long Acting Insulin: Glargine, Lantus, Basaglar, Detemir/Levemir,Toujeo, Semglee, or Degludec
- □ Other: _____

***MAY USE AS DISPENSED BY PHARMACY.** Opened insulin must be discarded after 28 days. Opened insulin may be stored at room temperature; refrigerate unopened insulin supply.*

Insulin Delivery Device at School:
- □ Syringe & Vial
- □ Insulin Pen --- Specify Brand/Model: _____
- □ Pump --- Specify Brand/Model: _____

See *Addendum A: Provider Orders for Insulin Pump and Suspected Pump Failure*, page 6.

Insulin management at school:
□ Student is able to manage insulin (determine dose, draw up/inject, or program pump) independently (*Diabetes Self-Management Authorization Form* –or similar) signed; kept with student's records/DMMP)
□ Student needs supervision or assistance (circle one) to manage insulin (determine dose, draw up/inject, or program pump)
□ Other: _____

□ Parent/Guardian are authorized to adjust insulin dosage as needed. This does not require provider order. Parents/Guardians need to communicate on-going modifications of carb counting/insulin coverage to School Nurse in writing with signature. Use the *Insulin Dosing Instruction* page 3 (make copies) for updates.
** The School Nurse should notify the provider of need for frequent modifications by parent/guardian to determine need for re-evaluation of DMMP orders.*

## Management of Meals and Snacks at School:

□ Student is able to manage carbohydrate calculations (carb counting) and meal/snack time needs independently (*Diabetes Self-Management Authorization Form* or similar signed and kept with student's records/DMMP)
□ Student needs supervision or assistance (circle one) to manage carbohydrate calculations (carb counting) and meal/snack time needs

Meals/Snacks Carb Counts: □ Not on a fixed carb count □ On fixed carb count: _____ grams CHO/meal
_____ grams CHO/snack

***Please see Physical Activity (Exercise/Sports) Management section (page 5) for guidance on snacks before/after physical activity.***

Scheduled snacks: Please describe:_____

Guidelines for food in classroom (e.g. class party, potluck, etc): _____

***Foods to avoid: candy, liquid sugars such as soda, fruit juice, Gatorade. Use only for low blood glucose.***
Other: _____

**Reminder not to cover fast acting carbs with insulin when used for low blood glucose treatment.*

*School:_____ Student Name:_____ DOB:_____ ID#: _____ Date Updated:_____*
*For Updated Instructions: Parent/Guardian Signature: _____ Provider Signature: _____*

***This page may be copied and used separately with the School Health Office Student Diabetes Record for meal time management***

## Insulin Dosing Instructions

### Blood Glucose Correction and Carbohydrate Coverage

**For individual correction and coverage ratios for different times/meals, see Addendum C: Individual Mealtime Insulin Dosing Instructions pg.8*

**Correction Dose:** *(With Insulin as noted on page 2 of DMMP)* *** Correction can be made every 3 hours as needed.*

Blood Glucose: _____ units of insulin for every _____mg/dL starting at target of _____mg/dL.

☐ Utilize blood glucose correction scale in next section.

**Carbohydrate Coverage:** *(With Insulin as noted on page 2 of DMMP)*

Meals/snacks: _____ units of insulin for every _____ grams of carbohydrate (carbs)

☐ Not yet Carb counting. Pre-meal insulin dose: _____ units before breakfast. _____ units before lunch.

****If using Insulin Pump, or smart pen, use dosing recommended by bolus calculator. Please note that this may vary from Dosing listed below.***

*In the event of pump failure use dosing as listed above (and the dosing scales below) and see *Addendum A: Provider Orders for Insulin Pump and Suspected Pump Failure*, page 6.

### Dosing Scales

*Pre-meal, check blood glucose and count meal carbs to determine insulin needs.

| Blood Glucose Correction | + | Food Carbohydrates Coverage |
|---|---|---|
| Under _____ = _____ Units | | _____ Grams = _____ Units |
| _____ to_____= _____ Units | | _____ Grams = _____ Units |
| _____ to_____= _____ Units | | _____ Grams = _____ Units |
| _____ to_____= _____ Units | | _____ Grams = _____ Units |
| _____ to_____= _____ Units | | _____ Grams = _____ Units |
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| _____ to_____= _____ Units | | _____ Grams = _____ Units |
| _____ to_____= _____ Units | | _____ Grams = _____ Units |
| _____ to_____= _____ Units | | _____ Grams = _____ Units |

***** Remember: The "3 hour rule" is about insulin correction, not carbohydrate coverage.***

### Home / Overnight Field Trip Management

Daily Long Acting Insulin: _____ Units AM, _____ Units at lunchtime, _____ Units at dinnertime, _____ Units at bedtime

*BEDTIME/OVERNIGHT corrections with rapid acting insulin:*

☐ At bedtime, correct blood glucose if OVER: _____ mg/dL

☐ Overnight, check blood glucose at _____, correct if OVER: _____ mg/dL

If blood glucose is less than _____mg/dL at bedtime, give a _____ gram/CHO + protein snack. **NO** insulin coverage for this snack.

Additional Orders/Notes:_____

_____

_____

_____

_____

| Bedtime and Overnight Correction Scale |
|---|
| Under _____ = _____ Units |
| _____ to_____= _____ Units |
| _____ to_____= _____ Units |
| _____ to_____= _____ Units |
| _____ to_____= _____ Units |
| _____ to_____= _____ Units |
| _____ to_____= _____ Units |
| _____ to_____= _____ Units |
| _____ to_____= _____ Units |

## Hypoglycemia (Low Blood Glucose) Management

**Hypoglycemia (Low Blood Glucose) = _____mg/dL and/or Physical Symptoms**

**Symptoms of Hypoglycemia:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Shaky | Headache | Weak | Clumsy | Sweaty | Drowsy | Hungry | Pale |
| Uncooperative | Irritable | Confused | Behavior Changes | Other:_____ | | | |

**Precautions for School Staff**

- *Never leave this student unattended! If treatment is to be provided in the Health Office, a responsible adult needs to accompany the student to the Health Office.*
- *If possible, check blood glucose if student has not done so and is symptomatic.*
- *Notify School Nurse when treatments are performed*.

**Low Blood Glucose Treatment:**

☐ Give 15 grams of fast acting carbohydrate. May use 4 ounces of juice or regular soda; 3-4 glucose tablets; or glucose gel
Do **NOT** cover this carb with insulin. The carbohydrate is given to treat the low blood glucose.

☐ Recheck blood glucose in 15 minutes.

If blood glucose is still below _____mg/dL give another 15 grams of carbohydrate.
May repeat intervention until glucose is at or above ____ mg/dL (see next intervention)

If the blood glucose is **above** _____mg/dL and:

1. If next meal is greater than ____ minutes away:
   - ☐ Give ____ gram CHO snack, and DO NOT cover with insulin
   - ☐ Give protein snack with <____gram CHO, and DO NOT cover with insulin

**OR**

2. If at meal time, may give breakfast/lunch and cover carbs with insulin per Insulin Dosing Instruction page

☐ Make sure the student feels well before leaving current location.

☐ Comments_____

**Treatment if disoriented, combative, and incoherent but is conscious:**

☐ Give 1⁄2 to 1 tube of glucose gel or cake decorating gel. Place gel between cheek and gum.
Massage the outside of cheek to facilitate absorption through the membrane of the cheek.
Encourage student to swallow.

☐ Recheck blood glucose in 10 minutes.
If still below _____mg/dL, repeat treatment with glucose gel.

☐ Give sugar containing liquid and snack when student is alert and able to swallow safely.

☐ Comments_____

**Treatment for seizures, loss of consciousness, inability/unwillingness to take gel or juice**:

☐ Stay with student

☐ Position student on side

☐ Give glucagon immediately:
- □ Baqsimi Nasal Glucagon (3mg)
- □ Gvoke: ☐ HypoPen (auto-injector); dose_____ ☐ PFS (pre-filled syringe); dose_____
- □ Glucagon Emergency Kit 1mg/mL by IM injection; dose _____
- □ Other: _____

☐ Call 911 and notify parent/guardian

☐ Comments_____

_____

***Whenever possible, diabetes management can occur in the classroom.***

*Ensuring full access to educational programming is the goal of Diabetes care and support in the school. Teachers and staff receive training to enable them to help in the care of students with diabetes. Students with symptoms of out-of-range glucose should not be left unattended by an adult or sent to health office alone.*

## Hyperglycemia (High Blood Glucose) Management

**Hyperglycemia (High Blood Glucose) =** □ 250 mg/dL (if on insulin pump) □ 300 mg/dL □ _____mg/dL

**Symptoms of Hyperglycemia:**

Extreme Thirst Frequent Urination Abdominal Pain Headache Nausea/Vomiting Other:_____

□ 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 unrestricted access to restroom.

□ *Check Ketones* --- □ Urine OR □ Blood

**** ***If student is on an insulin pump and ketones are present, call parent/guardian and follow directions in Addendum A: Provider Orders for Insulin Pump and Suspected Pump Failure, page 6.***

If Trace or Small Ketones (0.1 - 0.5mmol/L if measuring blood)

- Call parent/guardian. Consider insulin correction dose using scale on page 3, (may administer every 3 hours)
- *Can return to class and PE if no symptoms.*
- Recheck glucose and ketones in 1 to 2 hours.

If Moderate or Large Ketones (0.6 – 1.4 mmol/L or >1.5 mmol/L blood ketones)

- This may be serious and requires action. Call parent/guardian. If unavailable, contact provider.
- Administer correction dose of insulin via injection/pen per guidance by parent/guardian or provider (follow correction scale in DMMP) - may administer every 3 hours.
- If student is on an insulin pump this could indicate pump failure. Call parent/guardian and follow directions in *Addendum A: Provider Orders for Insulin Pump and Suspected Pump Failure,* page 6.
- Pump: change infusion site/cartridge, or use back up insulin delivery system. If using Automated Insulin Delivery system, contact parent/guardian about turning off automatic pump features.
- No physical activity until ketones are cleared. Recheck ketones in 1-2 hours.
- If symptomatic, report to parent/guardian and request pick-up from school.
- If symptoms progress to changes in mental status, respiratory distress: call 911 and notify parent/guardian.

## Physical Activity (Exercise/Sports) Management

*Notes: A fast acting carbohydrate such as juice, regular soda, Gatorade, or glucose tabs should be readily available during physical activity such as PE, recess, exercise, and sports. Set up activity mode in the pump (if this feature is available) 30 minutes prior to exercise. Student should be asymptomatic prior to participating in sports.*

Snacks: □ before physical activity □ after physical activity □ as needed

Check blood glucose: □ before physical activity □ after physical activity □ other: _____

**Guidelines for treatment (including restrictions) related to physical activity:**

Hypoglycemia with or without symptoms of hypoglycemia

□ If blood glucose is below _____mg/dL, treat for hypoglycemia per instructions on page 4. Delay exercise for treatment.

□ If blood glucose is at low end of normal range or ____ mg/dL, provide snack as indicated: _____ May exercise.

Hyperglycemia with or without symptoms of hyperglycemia

□ If glucose is above 300 mg/dL check ketones. If ketones are moderate to large (blood ketones are ≥ 0.6 mmol/L), restrict activity and notify parent/guardian and provider.

***THIS DIABETES MEDICAL MANAGEMENT PLAN HAS BEEN APPROVED BY:***

_____ _____ _____ _____

Healthcare Provider* Date Diabetes Educator* Date

***I give my permission to the school, school nurse, licensed/unlicensed assistive personnel, and other designated staff member(s) to perform and carry out the diabetes care tasks as outlined by this Diabetes Medical Management Plan for my child, and I acknowledge that I have received a copy of the signed plan.***

***I also consent to the release of the information contained in this plan to all staff and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I will notify extra-curricular staff about health plan and care to be given during after school activities. I give my permission for the school nurse to contact my child's healthcare provider(s) regarding the above condition.***

_____ _____

Parent/Guardian* Date

**Contact information on page 1 of DMMP*

***ACKNOWLEDGED AND RECEIVED BY:***

_____ _____

School Nurse Date

*IHP: Risk for Unstable Blood Glucose Level*

*Goal: Glucose within range/Access educational programming/Gain awareness and independence in Diabetes self-care*

## Addendum A: Provider Orders for Insulin Pump and Suspected Pump Failure

**Insulin Pump Brand/Model**:_____ □ Use Insulin dosing programmed into pump
Is this an Automated Insulin Delivery System? □ No □ Yes

In event of suspected pump failure, see section "Follow Directions Below If Ketones Are Present"

Student is able to operate insulin pump: □ with supervision/assistance □ independently
Student can troubleshoot problems (e.g. ketones, pump malfunctions, etc.): □ with supervision/assistance □ independently

*Note: Please visit the Association of Diabetes Care & Education Specialists website for up-to-date information on Diabetes care and technology at www.diabeteseducator.org. See article:* ***Understanding Automated Insulin Delivery (AID) Systems*** *at https://www.diabeteseducator.org/docs/default-source/dana-files/insulin_delivery_systems2_aid(1)4d90eaea-9dcc-4b0a-9ec0-3b1fa9dca575.pdf?sfvrsn=2ab06b59_3*

**Why are students using insulin pumps at risk for ketoacidosis?**
Pump users have no long-acting insulin in their bodies. If the flow of insulin from the pump stops, the body will make ketones very quickly.

**What are the signs of high ketones?**
•Nausea •Stomach Cramps •Vomiting •Trouble breathing

Usually blood glucose level is high when there is a high level of ketones, but ketoacidosis can occur at any blood glucose level. A person may think they have the stomach flu when, in fact, they are becoming ill from high ketones. Symptoms are exactly the same. If insulin is not given immediately, ketoacidosis will occur.

Test urine or blood ketones if the following symptoms are present:
•Feeling sick or nauseated •Blood glucose over 300 •Blood glucose over 250 for 2 or more hours
**** Please also be sure to check the expiration date on strips; if blood ketone strips are past the exp. Date, the machine will not read them.*

**FOLLOW DIRECTIONS BELOW IF KETONES ARE PRESENT**

**Less than 0.6 mmol/L blood ketones or Trace/Small urine ketones**

- ADMINISTER correction bolus through insulin pump
- RECHECK blood glucose and ketones in 1 hour
- GIVE 4-8 ounces sugar free liquids (water) by mouth every hour
- If blood glucose is not improved in one hour, ADMINISTER insulin correction dose by syringe using sliding scale in DMMP for dose calculation
- REMOVE catheter and REPLACE insulin, cartridge, tubing, and catheter
- RECHECK blood glucose in 2 hours
- ADMINISTER next bolus through pump with new set in place
- CALL parent/guardian

**0.6 to 3.0 mmol/L blood ketones or Moderate/Large urine ketones**

- ADMINISTER correction dose of back-up supply insulin via syringe/pen immediately using sliding scale in DMMP for dose calculation
- GIVE 4-8 ounces sugar free liquids (water) by mouth every hour
- REMOVE catheter and REPLACE insulin, cartridge, tubing, and catheter
- RECHECK blood glucose and ketones every 2-3 hours.
- ADMINISTER next bolus through pump with new set in place
- CALL parent/guardian

**Greater than 3.0 mmol/L blood ketones**

- IMMEDIATELY: ADMINISTER **25% increased** correction dose using sliding scale in DMMP for dose calculation (using back-up supply of insulin via syringe/pen).
- REMOVE catheter and REPLACE insulin, cartridge, tubing, and catheter
- CHECK blood glucose and ketones every 2-3 hours and set future correction doses using bolus wizard.
- GIVE 4-8 ounces sugar free liquids (water) by mouth every hour
- CALL healthcare provider and parent/guardian

## Addendum B: Provider Orders for Continuous Glucose Monitor (CGM)

| | |
|---|---|
| **CGM Brand/Model**:_____<br><br>CGM readings should be used to make treatment decisions, including insulin dosing, and low treatments. Confirm CGM readings with a blood glucose (finger stick) only when:<br>• Symptoms don't match the CGM reading<br>• System is not displaying trend arrows<br>• CGM is requesting calibration<br>• CGM reading is BELOW _____mg/dL or GREATER THAN _____ mg/dL<br>• Other: _____ | **The CGM may need to be calibrated during the school day. Calibrate the CGM with a blood glucose reading ONLY if prompted. Do NOT calibrate CGM if glucose is changing rapidly.<br><br>**Intermittent-scan CGMs estimate glucose levels continuously; but, the CGM must be scanned with a separate receiver or smartphone every few hours to view and store the data. This is different from calibration. |

A continuous glucose monitor (CGM) measures glucose in the interstitial fluid every 5 minutes. There are 3 parts to the CGM:

- The glucose sensor under the skin; in the interstitial fluid.
- The transmitter on the skin
- The receiver/reader that displays the sensor glucose readings transmitted from the sensor (often a smart phone)

Because of the way glucose moves in the body, and the measurement of interstitial fluid vs. blood, there will always be a difference between blood glucose meter readings and CGM glucose sensor readings. The difference can be up to 30mg/dL or more if there are trend arrows indicating changes in that moment.

***If CGM readings will be used to make treatment decisions, follow provider instructions above on when to confirm a CGM reading with a blood glucose reading. When CGM issues are suspected, confirm the blood glucose with a blood glucose meter.***

### Alarms

There are several types of alarms that can be set on a CGM. Generally these include:

- High alarm
- Low alarm
- Rate of change of glucose level alarm

If a low blood glucose alarm appears, check the blood glucose and treat according to the *Hypoglycemia (Low Blood Glucose) Management* instructions on page 4. It is important to use finger stick for the 15 minute re-check.

### Trend Arrows

A trend arrow should show next to sensor glucose readings on the receiver screen. Trend arrows show the direction and speed the glucose is changing.



Glucose is steady and not changing any more than 1 mg/dl each minute. In 30 minutes: 100mg/dL → 100 mg/dL



Glucose is rapidly rising > 3 mg/dl each minute.
In 30 minutes: 100mg/dL → 190 mg/dL



Glucose is quickly rising 2 to 3 mg/dl each minute.
In 30 minutes: 100mg/dL → 160 mg/dL



Glucose is rising 1 to 2 mg/dl each minute.
In 30 minutes: 100mg/dL → 130 mg/dL



Glucose is rapidly falling > 3 mg/dl each minute.
In 30 minutes: 100mg/dL → 10 mg/dL



Glucose is quickly falling 2 to 3 mg/dl each minute.
In 30 minutes: 100mg/dL → 40 mg/dL



Glucose is falling 1 to 2 mg/dl each minute.
In 30 minutes: 100mg/dL → 70 mg/dL

### Sensor Failure

If there is a sensor failure it is not necessary to replace the sensor during the school day. DO NOT DISCARD the transmitter.

## Addendum C: Individual Mealtime Insulin Dosing Instructions

If different coverage ratios:

**Breakfast:** ____ unit of rapid acting insulin per_____ grams of carbohydrate
**Lunch:** ____ unit of rapid acting insulin per_____ grams of carbohydrate
**Dinner:** ____ unit of rapid acting insulin per_____ grams of carbohydrate
**Snack:** ____ unit of rapid acting insulin per_____ grams of carbohydrate

**Dosing Scales:**

**Blood Glucose Correction + Food Carbohydrates Coverage**

| | **Breakfast** | **Lunch** | **Dinner** |
|---|---|---|---|
| Under _____ = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |
| _____ to_____= _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |
| _____ to_____= _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |
| _____ to_____= _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |
| _____ to_____= _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |
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| _____ to_____= _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |
| _____ to_____= _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |
| _____ to_____= _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |
| _____ to_____= _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |
| _____ to_____= _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |
| _____ to_____= _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units | _____ Grams = _____ Units |

*** Remember: when meals or snacks, always take rapid-acting insulin to cover the carbohydrate, no matter how recent last insulin. The "3 hour rule" is about insulin correction.*

## Addendum D: Diabetes Self-Management Authorization

**Medication Administration and Monitoring At School**

*School:_____ Student Name:_____ DOB:_____ ID#: _____ Date Updated:_____*

**TO BE COMPLETED BY PARENT/GUARDIAN:**

I hereby give my permission for my child to self-administer medication/blood glucose monitoring at school as prescribed by my child's prescribing health care provider, and I authorize reciprocal release of information related to my child's health/medications between the school nurse and the prescribing healthcare provider.

Signature of Parent/Guardian: _____ Date: _____
Phone number: _____ Work Phone number: _____

**TO BE COMPLETED BY STUDENT:**

**I agree to:**

□ Follow my health care provider's orders.
□ Refill my prescriptions before they run out (or help remind my parent/guardian to do so).
□ Use the correct medication technique (demonstrate to the nurse).
□ Keep supplies on hand to treat low blood glucose.
□ Not allow anyone else to use my medication.
□ Maintain a written record of my medication administration at school.
□ Keep a current supply of my medication.
□ Keep spare medication/blood glucose testing supplies in the health office.
□ Check-in with the school nurse: □ Daily, □ Weekly, □ Monthly, □ Other_____
(Note what day of the day and time: _____)
□ Notify the school nurse or _____ under the following circumstances:
□ I need to treat a low blood glucose more than 2 times a week at school.
□ My blood glucose readings are consistently out of my goal range or I am having frequent symptoms of high or low blood glucose.
Other: _____

**I know:**

□ Who my health care provider is and how to contact them
□ Where my pharmacy is and how to contact.
□ To see my health care provider for ongoing diabetes management at least twice a year.
□ To call my health care provider if I am having blood glucose levels that are consistently out of my goal range.

Student signature: _____ Date: _____

**TO BE COMPLETED BY SCHOOL NURSE:**

□ This student has demonstrated mastery related to their diabetes medication and self-care skills.
□ This student needs reinforcement of their diabetes medication and self-care skills.
□ This student may independently manage diabetes and should check in with me according to schedule in previous section.

School Nurse Signature: _____ Date: _____

***NOTE:*** *If the school nurse does not concur with the health care provider's instructions after assessing the competencies of the student, the school nurse will contact the health care provider and parent/guardian to agree upon a plan. Permission for the self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement.*