



Anchorage School District

Diabetes Injection Care Plan



Student:	DOB:	Grade:	Student ID:
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Hx of Condition and Supplies *(parent/guardian to provide supplies to the School Nurse)*

☐ Type I Diabetes	☐ Type II Diabetes	☐ Fast Acting Insulin: _____
☐ CGM Model: _____	☐ Backup glucometer	☐ Glucometer strips
☐ Ketone test supplies	☐ Emergency meds	☐ Backup long-acting insulin
☐ Other: _____	☐ Pen needles	

☐ Step 1: Calculate Blood Glucose Correction Dose (BGCD)

☐ Check current blood glucose	☐ before breakfast	☐ before lunch	☐ other: _____
☐ May use CGM for dosing			
☐ Use glucometer if,	☐ BG rapidly changing when dosing	☐ To confirm hypoglycemia	
	☐ Hyperglycemia >400	☐ Calibration	☐ Other: _____
☐ If BG is less than 70 mg/dL, treat with carbohydrate per hypoglycemia protocol.			
☐ If BG is greater than Target BG, calculate and give BGCD according to the formula below.			
Parameters Target Blood Glucose: _____ mg/dL Correction Factor: _____		Formula $\frac{(Current\ BG - Target\ BG)}{Correction\ Factor} = BGCD$	
*Skip BGCD if student received a bolus of fast acting insulin within the last 3 hours (includes CCD)			

☐ Step 2: Calculate Carb (CHO) Coverage Dose (CCD)

☐ Calculate the total grams of CHO that the student thinks they will eat from their meal.		
☐ Calculate CCD in units of fast acting insulin by using the parameters and formula below:		
Parameters ☐ All meal/snack intake ☐ Snacks ☐ Time/M meal: _____ ☐ Time/M meal: _____ ☐ Time/M meal: _____	CHO Ratio 1 U insulin per _____ CHO 1 U insulin per _____ CHO 1 U insulin per _____ CHO 1 U insulin per _____ CHO 1 U insulin per _____ CHO	Formula $\frac{Total\ grams\ of\ CHO\ intake}{CHO\ Ratio} = CCD$

☐ Step 3: Administer fast acting insulin bolus.

CCD + *BGCD = Total Insulin Dose	Round dose to the nearest ☐ Half Unit ☐ Whole Unit
*Skip BGCD if student received a bolus of fast acting insulin within the last 3 hours (includes CCD)	

Dosing Adjustments

☐ Yes ☐ No	Dosing (including CHO ratio, Correction Factor, Target BG, and adding on a long-acting dose) can be adjusted 20% by parent/guardian without a new Care Plan.
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Medical Provider:	NPI:	Phone:
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Additional Medications

☐ Glucagon/Gvoke ____ mg IM or SQ PRN for hypoglycemia <70 mg/dL and unable to swallow, or seizure, or unconscious. Refer to "Algorithm for Blood Glucose Results."
☐ Baqsimi 3mg Intranasal PRN for hypoglycemia <70 mg/dL and unable to swallow, or seizure, or unconscious. Refer to "Algorithm for Blood Glucose Results."
☐ Long-acting insulin (_____) ____ units SQ DAILY ☐ Given at home ☐ Given at school
☐ Other:

Other Diabetes Care Orders

General

- ☐ If not symptomatic for hypoglycemia, always check BG in ☐ Classroom ☐ Health office ☐ No restriction
- ☐ If student has symptoms of hyper/hypoglycemia, check BG and follow "Algorithm for Blood Glucose Results."
- ☐ If BG greater than or equal to 250 mg/dL, repeat BG check in 2 hours and refer to "Algorithm for Blood Glucose Results" for ketone guidance.
- ☐ Check ketones with signs of illness including abdominal pain, upset stomach, and vomiting.
- ☐ Students must always have cell phone or other monitoring device available to them.
- ☐ School Nurse must have a device to monitor student's CGM reading from Health Office.
- ☐ The student will not leave campus for school sanctioned activities for any reason without first coordinating with the school nurse (*school nurse should address this in the 504/IEP*).

Physical Activity (*PE, Recess, After School Sports*)

- ☐ Quick acting source of glucose (glucose tab or juice) should be available at the site of the physical activity.
- ☐ If ketones are identified as part of the "Algorithm for Blood Glucose Results" do not participate in physical activity until ketones are cleared.
- ☐ Student will monitor BG hourly during all physical activity (*PE, recess, after school sports*). Refer to "Algorithm for Blood Glucose Results"
- ☐ Before activity, check BG using CGM or glucometer:
 - ☐ If less than ____ **mg/dL**, correct BG per protocol to above ____ **mg/dL** before participation.
 - ☐ If less than ____ **mg/dL**, consume ____ **grams of CHO with protein** before participation.
- ☐ Student should eat ____ **grams of CHO** ☐ Pre-activity ☐ Q30min ☐ Q1H ☐ Post-activity

End of Day

- ☐ Check BG before leaving school at end-of-day:
 - ☐ If less than ____ **mg/dL**, correct BG per protocol to above ____ **mg/dL** before transport home.
 - ☐ If less than ____ **mg/dL**, consume ____ **grams of CHO with protein** before transport home.

Additional Orders:

Medical Provider:	NPI:	Phone:
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Medical Provider Assessment of Student's Diabetes Management Skills

Skill	Independent	Supervise*	Dependent	Notes
Check blood glucose	☐	☐	☐	
Count carbohydrates	☐	☐	☐	
Calculate insulin dose	☐	☐	☐	
Insulin administration	☐	☐	☐	
Troubleshoot CGM alarms	☐	☐	☐	
<i>*The nurse or parent/guardian authorized staff are expected to observe for accuracy and completion of skills requiring supervision.</i>				

Medical Provider:	NPI:	Phone:
Signature:	Email:	Date:

Parent/Guardian Authorization

I request that the medication(s) and diabetes care outlined on this plan be given to my child. I will provide needed medications or supplies for care in school. Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the way it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success. I understand that ANY remaining diabetes care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the ASD school year calendar.

Name:	Phone:
Signature:	Date:

This authorization expires at the end of the current school year.

Nurse Acknowledgement

I acknowledge that as a licensed RN in the State of Alaska, employed by the Anchorage School District, in accordance with AS 12 AAC 44.970 I understand that I cannot delegate specific nursing functions contained within this Care Plan to Unlicensed Assistive Personnel (UAPs). However, I also recognize my professional responsibility to assist in the training of other school staff members as authorized by the parent/guardian. I understand that my role is to ensure proper training and guidance, and that liability for actions taken by individuals authorized by the parent/guardian to provide care, after my training, resides with the authorized individual.

Nurse:	Initials:
Signature:	Date:

Student's usual LOW blood glucose symptoms

- | | |
|---|--|
| ☐ Shaky or jittery | ☐ Uncoordinated |
| ☐ Sweaty | ☐ Irritable, nervous |
| ☐ Hungry | ☐ Argumentative |
| ☐ Pale | ☐ Combative |
| ☐ Headache | ☐ Change in personality |
| ☐ Blurry vision | ☐ Change in behavior |
| ☐ Sleepy | ☐ Unable to concentrate |
| ☐ Dizzy | ☐ Weak, lethargic |

ALGORITHM FOR BLOOD GLUCOSE RESULTS

Student Name: _____

Check Blood Glucose

Below 70

70 - 125

126 - 250

Above 250

1. Give ____ gm fast-acting carbohydrate
2. Observe for 15 minutes then retest blood glucose.
 - a. If less than 70 mg/dL, repeat ____ gm carbohydrate and retest in 15 min.
 - b. If over 70 mg/dL and not eating a meal within an hour, give 5-10gm carbohydrate and protein snack without insulin coverage.
3. Notify school nurse and parent if no improvement.
4. Student should not exercise.

If participating in physical activity, refer to "Physical Activity" orders, otherwise no action needed.

No action needed

EXERCISE AND SPORTS

- ✓ Assure has quick access to water for hydration, fast-acting carbohydrates, snacks and monitoring equipment.
- ✓ Student should not exercise if blood glucose level is below 70 mg/dL or if has ketones.

8-10 GM of fast-acting CHO

- 1 pouch Honest juice
- ¼ cup of juice
- 2 glucose tablets
- 2-3 Starbursts
- 2 sugar packets

Do not give chocolate

15 GM of fast-acting CHO

- ½ cup of regular juice
- 3-4 glucose tablets
- Tube of glucose gel
- 1 Welch's gummy
- 4 Starbursts
- 1 pouch Caprisun
- 1 Yoggigummy pouch.

Do not give chocolate

Student's usual HIGH blood glucose symptoms

- | | |
|---|--|
| Hyperglycemia | Emergency Levels |
| ☐ Increased thirst | ☐ Extreme thirst |
| ☐ Dry mouth | ☐ Nausea and vomiting |
| ☐ Frequent urination | ☐ Severe abdominal pain |
| ☐ Change in appetite | ☐ Fruity breath |
| ☐ Blurry vision | ☐ Dyspnea |
| ☐ Fatigue | ☐ Lethargy |
| ☐ Other: _____ | |

INJECTIONS

1. Give BGCD and recheck blood glucose in 2 hours
2. Provide free, unrestricted access to water and the restroom.
3. Check ketones if symptomatic or ill; or if blood glucose >250 twice in a row; or if missed last long-acting insulin injection.
 - a. If ketones are absent, encourage exercise and water
 - b. If ketones present:
 - No exercise; give water
 - Consult with provider for BGCD
 - c. Notify parent/guardian for pick-up

PUMP (troubleshoot pump for tubing kinks, insulin supply, etc)

1. If pump is not operational; or BG above 250 x2; or symptomatic for ketones:
 - a. Change infusion set, or transition to injections.
 - b. Check ketones
 - If ketones are absent, encourage exercise and water
 - If ketones present, no exercise; give water, and consult with provider for BGCD
2. If pump is operational and two hours since last bolus, treat with BGCD via pump. Re-check blood glucose in two hours.
3. Notify parent/guardian for pick-up

CALL 911 if the student has ketones with altered LOC, Kussmaul breathing, or difficulty awakening. Notify school nurse, parent and healthcare provider.

CALL 911 if student becomes unconscious, seizures or is unable to swallow

- Turn student on side to ensure open airway.
- Give glucagon as ordered. Keep student in recovery position on side.
- Notify school nurse, parent and HCP
- Wait 15 minutes;
 - If not responsive or still unsafe to swallow but BG remains <70 mg/dL, repeat glucagon.
 - If responsive, BG remains <70 mg/dL and patient can safely swallow, provide 15 gm of CHO.
 - If BG is > 70 mg/dL, provide a 10-15 gm CHO snack with protein without insulin coverage.

***Never send a child with suspected low blood glucose anywhere alone.**



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Non-Delegable Nursing Duties Parental Authorization

Federal Laws require all students attending public schools to have access to health care during the school day and for school sponsored activities if necessary for the student to participate in a school program.

The Alaska Board of Nursing (BON) does not authorize registered nurses to delegate certain medications and procedures. Parental Delegation of these medications and procedures when a school nurse is not available to administer them is allowed in 12 AAC 44.975. In an Alaska BON advisory opinion, the "Medication Administration in the School Setting Delegation Decision Tree" was adopted as a plan to allow parents to delegate to school staff with nurse involvement in training and follow-up. The trained school staff must provide care for the student consistent with this Care Plan based on healthcare provider instructions and parent input.

Parent/Guardian Authorization

Staff Authorized to perform diabetic management:	
Name: _____	Position: _____
Name: _____	Position: _____
Name: _____	Position: _____
Name: _____	Position: _____
Non-delegable medication(s): _____	
Training	
☐ _____ (initial) I ATTENDED the training session(s) provided to the school staff identified above, agree that the content was appropriate for diabetic management for my child.	
☐ _____ (initial) I DID NOT ATTEND the training session(s) provided to the school staff identified above but have reviewed the curriculum and agree that the content is appropriate for diabetic care for my child.	

I, the parent/legal guardian, understand that in the absence of the school nurse, other trained school staff indicated below will administer this medication. I agree to defend, and hold named school district employees harmless from any liability resulting from the medication or the manner, in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication.

I hereby acknowledge that I have read and understand this form and agree to its content. I have authorized the nurse to train school staff using a standardized curriculum to administer the medication(s) below to my child according to my child's IHP when the school nurse is not available.

Parent/Guardian Name: _____	Phone: _____	
Signature: _____	Initials: _____	Date: _____

This authorization expires at the end of the current school year.