



Diabetes Medical Care Plan

This care plan is valid for one (1) calendar school year only and must be updated by the prescribing physician, if any changes are made throughout the year to this plan.

Student's Name: _____ School Year : _____

Date of Birth: _____ School/Program: _____

Age: _____ Grade: _____ Teacher: _____

Page one of this care plan is to be completed, signed and dated by a parent/guardian. All pages of this care plan are to be completed, signed and dated by the treating licensed physician. Without **both** signatures this care plan is not valid. Parent/guardian is responsible for supplying all ordered medications and any other supplies/equipment necessary to the school. It is the responsibility of the parent to make sure medications are not expired and any changes to plan is communicated with the school.

Contact Information

First Contact

Second Contact

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone (1): _____ Phone (1): _____

HISTORY and MANAGEMENT

Age when diabetes was diagnosed _____ Type I Diabetes YES NO Type II Diabetes YES NO

Can student perform their own blood glucose (BG) testing YES NO Please monitor/help YES NO

Will student have a glucometer and supplies for school use only YES NO

Routinely test BG: Before Snack Before Lunch Before Exercise After Exercise Other _____

Target BG range _____ to _____ Does the student have a continuous glucose monitor (GCM): YES NO

If student has a GCM Brand/model: _____ Alarms set for: Low BG: _____ High BG: _____

Insulin will be given at school YES NO If YES, please circle: Syringe/vial Insulin pen Pump

Can student give their own insulin or insulin bolus, if on pump YES NO Please monitor/help YES NO

Accommodations as needed are allowed. A more detailed medical plan may be needed to manage your child's diabetes at school. Use the plan you and your medical provider feel is best for daily management.

YES NO I have read the attached information regarding section 504 eligibility

YES NO I wish to be contacted regarding a 504 evaluation

Other considerations/instructions: _____

I agree to have the information in this plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having diabetes to better identify needs. 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 give permission for trained staff to administer any medication ordered for diabetes in this plan and to contact the ordering physician/licensed prescriber for clarification of this plan, if needed.

Parent Signature

Date

Holly Area Schools do not have medical personnel present to administer medication / treatment. If appropriate, please order medication / treatment to be administered at home.

Student Name: _____ Birthdate: _____ Grade: _____

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 if:

❖ **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 *

Prior to **Breakfast:** or Immediately after Prior to **Lunch:** or Immediately after

Prior to **Snack (carb coverage only):** or Immediately after Prior to _____: or Immediately after NA

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.

Office staff assisting in filling out this form: _____

Signature: _____ Date: _____



Student Name: _____ Birthdate: _____

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:

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 or 1.0 mg

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

Physician please fill out the hypoglycemia and hyperglycemia treatments on the following two pages

Prescriber’s Signature: _____ Date: _____

(No stamped signatures, please)

Print Name/Title: _____ NPI#: _____

Address: _____

Phone: _____ FAX: _____

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.

Symptoms of a Low Glucose Level (Hypoglycemia)

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: _____

Actions for Treating Hypoglycemia

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

Student Name: _____

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.

Symptoms of a High Glucose Level (Hyperglycemia)

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: _____

Actions for Treating Hyperglycemia

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

