Holly Area Schools

Diabetic Medical Care Plan

This care plan is valid for one (1) calendar school year only and must be updated by the prescribing physician, and 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 certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medications at school. I will not hold the HAS Board of Education, it's personnel, or employee's responsible for complications to medication or treatment/care administered pursuant to this plan.I give permission for trained staff to administer any medication ordered for diabetes in this plan and authorization to contact the ordering physician/licensed prescriber for clarification of this plan, if needed.

____	____________________
Parent Signature	**Date**

Holly Area Schools is not a medical facility. To extent practicable and safe for the student, medication should be administered during non-school hours.

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: ________________________

Over→

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.

HAS is not a medical facility. To the extent possible and safe for the student, medication should be administered during non-school hours.

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: ____

Office use only: Skyward Alert: ____ Email: ____ Date: _____ Initials: ______

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
Notify School Nurse or Designated School Personnel as soon as you observe symptoms. If possible, check glucose level via finger stick. **Do NOT send the student to the office alone!** Treat for hypoglycemia if glucose level is: ☐ less than _____ or less than _____ with symptoms. **WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.**	**Student is:** ✔ **Unconscious** ✔ **Having a seizure** ✔ **Having difficulty swallowing** **Follow Emergency Steps** **1. Administer Glucagon** **2. Call 9-1-1** **3. Activate MERT (Medical Emergency Response Team)**
"Rule of 15"	Administer Glucagon
☐ Treat with **15 grams of quick-acting glucose** (4 oz. juice or 3-4 glucose tabs) **OR** ☐ Treat with **30 grams of quick-acting glucose** (8 oz. juice or 6-8 glucose tabs) **if glucose level is less than _______** ☐ Wait 15 minutes. Recheck glucose level. ☐ Repeat quick-acting glucose treatment if glucose level is less than _______ mg/dL. ☐ Contact the student's parents/guardians. **Then:** ☐ If an hour or more before next meal, give a snack of protein and complex carbohydrates ☐ If mealtime and no difficulty swallowing, monitor and allow student to eat lunch while waiting to recheck glucose level. ☐ Once glucose level is greater than _______ and student has finished eating lunch, give insulin to **cover meal carbs only.**	☑ Stay with student, protect from injury, turn on side ☑ Do not put anything into the student's mouth ☐ Suspend or remove insulin pump (if worn) ☑ Administer Glucagon Per MAA Form: ☐ 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 ☐ Implement Medical Emergency Response: ✔ 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
Notify School Nurse or Designated School Personnel as soon as you observe symptoms.	**Call 9-1-1** **Activate Medical Emergency Response**
☐ **For glucose level less than 300:** ✔ 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) ☐ **For glucose level 300 or greater:** ✔ If mealtime, give insulin as prescribed (see Section I, Routine Management, Insulin Administration) ✔ Have student check ketones ☐ **Positive Ketones:** ✔ Call parent/guardian ▪ Trace or Small - attempt to flush, remain in school if feeling well and no vomiting ▪ 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: ▪ Is tubing disconnected? ▪ Is there wetness around the pump site, etc.? ☐ **Negative Ketones:** ✔ If not mealtime - offer water, return to normal routine if feeling well ☐ **If no ketone strips are available:** ✔ Treat as Positive Ketones ✔ Request strips from family	☐ Call 9-1-1 if severe symptoms are present. Severe symptoms **may** include: ✔ Abdominal pain ✔ Nausea/Repetitive Vomiting ✔ Change in level of consciousness ✔ Lethargy ☐ Implement Medical Emergency Response: ✔ 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.