Student Name: _____ **This Plan expires June 30, 20___**

School-based Medical Management Plan for the Student with Diabetes Mellitus

To be completed by Parent/Guardian

Student Name: _____ Birthdate: _____ Grade: _____

Address: _____

Mother/Guardian: _____ Phone: (home) _____ (cell) _____

Father/Guardian: _____ Phone: (home) _____ (cell) _____

Other Emergency Contact: _____ Phone: _____ Relationship: _____

Diabetes Health Care Provider: _____ Phone: _____

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 when symptomatic ☑ Perform finger stick if symptoms do not match CGM values

- **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

Breakfast: ☐ Prior to ☐ Immediately after **Lunch:** ☐ Prior to ☐ Immediately after **Snack (carb coverage only):** ☐ Prior to ☐ NA ☐ Immediately after

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.

Student Name: _____ This Plan expires June 30, 20___

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:

Student Name: _____ Date of Birth:_____ Grade: _____

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 ☐ 1.0 mg
   ☐ Auto-Injection, Gvoke HypoPen: ☐0.5mg/0.1mL ☐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. Additional training provided by a RN, PA, physician, or Certified Diabetes Educator to Designed School Personnel is required.

Prescriber's Signature: _____ Date: _____

(No stamped signatures, please)

Print Name/Title: _____ NPI#: _____

Address: _____

Phone: _____ FAX: _____

Parent/Guardian Authorization:

I request Designated School Personnel to administer the medications as prescribed by the above prescriber. 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 authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature:: _____ Date: _____

Reviewed by RN, PA, Physician, or Certified Diabetes Educator providing training to Designated School Personnel:

_____

Signature/Title Date

Student Name: _____ This Plan expires June 30, 20___

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 student to 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 ☐ 1.0 mg ☐ Auto-Injection, Gvoke HypoPen: ☐ 0.5mg/0.1ml ☐ 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: _____ This Plan expires June 30, 20___

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.

_____ _____

Parent/Guardian Signature (Void if not signed) Date Physician Signature Date

Student Name_____ This Plan expires June 30, 20_____

To be completed by Trainer of Student-specific School Health (SSH) Team in collaboration with all SSH Team members.

SECTION IV – Additional Supports

☐ Snack daily at: _____ ☐ Snack as needed for low glucose level ☐ Allow unlimited access to food

☐ Allow unlimited access to water or bathroom ☐ Have 15 grams of quick-acting glucose available at site of physical activity

☐ For special occasions that involve food: ☐ always contact parent for guidance **OR** ☐ student can self-manage

☐ Out of classroom, student will travel with: ☐ buddy ☐ adult

☐ always **OR** ☐ when support is requested or is obviously needed

☐ Fieldtrips - Student will be accompanied by trained school personnel, unless parent volunteers to attend (parent attendance not required)

☐ Extra-curricular Activities – Parent and student will inform DSP of participation to ensure trained school personnel are present

☐ Plan for access to food and appropriate support during School Emergencies developed/implemented

☐ Record all care provided/send documentation home: ☐ Weekly ☐ When requested by parent ☐ Other: _____

☐ Evaluate for eligibility for a Section 504 Academic Accommodations Plan

Location of Glucagon (Glucagon/Gvoke/Baqsimi): ☐ In Office ☐ In Classroom ☐ With Student ☐ Other: _____

Location of Other Diabetes Supplies (see attached list): ☐ In Office ☐ In Classroom ☐ With Student ☐ Other: _____

School Name: _____ Principal: _____

School Address: _____

SSH Team consists of:

Parent, Student, Designated School Personnel

AND

RN, Physician, PA, or Certified Diabetes Care and Education Specialist (CDCES)

The following Designated School Personnel have received training to support implementation of this plan:

_____	_____
Name	**Title**
_____	_____
Name	**Title**
_____	_____
Name	**Title**
_____	_____
Name	**Title**
_____	_____
Name	**Title**

Training provided by:

_____

Signature/Title Date

Individualized Health Care Plan (IHP)

Student: _____

School: _____

Grade: _____ School Year: _____

IHP Completed by: _____ Date: _____

IHP Review Dates: _____

Nursing Assessment Review Dates: _____

Nursing Assessment Completed by: _____ Date: _____

Nursing Diagnosis	Sample Interventions and Activities	Date Implemented	Sample Outcome Indicator	Date Evaluated
Managing Potential Diabetes Emergencies (risk for unstable blood glucose)	Establish and document student's routine for maintaining blood glucose within goal range including while at school: • Where to check blood glucose: ☐ Classroom ☐ Health room ☐ Other:_____ • When to check blood glucose: ☐ Before breakfast ☐ Mid-morning ☐ Before lunch ☐ After lunch ☐ Before snack ☐ Before PE ☐ After PE ☐ 2 hours after correction dose ☐ Before dismissal ☐ As needed ☐ Other:_____ • Student's self-care skills: ☐ Independent ☐ Supervision ☐ Full assistance • Brand/model of BG meter:_____ • Brand/model of CGM:_____		**Blood glucose remains in goal range** Percentage of time 0% 25% 50% 75% 100%	

Nursing Diagnosis (continued)	Sample Interventions and Activities (continued)	Date Implemented (continued)	Sample Outcome Indicator (continued)	Date Evaluated (continued)
Supporting the Independent Student (effective therapeutic regimen management)	**Hypoglycemia Management** **STUDENT WILL:** • Check blood glucose when hypoglycemia suspected • Treat hypoglycemia (follow Emergency Care Plans for Hypoglycemia and Hyperglycemia) • Take action following hypoglycemia episode • Keep quick-acting glucose product to treat on spot • Type: _____ • Routinely monitor hypoglycemia trends r/t class schedule (e.g., time of PE, scheduled lunch, recess) and insulin dosing • Report to and consult with parents/guardians, school nurse, HCP, and school personnel as appropriate		**Monitors blood glucose and appropriately responds to results** Percentage of time 0% 25% 50% 75% 100%	
Supporting Positive Coping Skills (readiness for enhanced coping)	**Create Positive School Environment** • Ensure confidentiality • Discuss with parents/guardians and student preferences about how school can support student's coping skills • Collaborate with parents/guardians and school personnel to meet student's coping needs • Collaborate with school personnel to create accepting and understanding environment		**Demonstrates positive coping** Percentage of time 0% 25% 50% 75% 100%	