

Children's Physician Group
DIABETES MEDICAL MANAGEMENT PLAN
School Year:

Student's Name: _____ Date of Birth: _____
Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____
Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____
Other emergency contact: _____ Phone #: _____ Relationship: _____
Insurance Carrier: _____ Preferred Hospital: _____

BLOOD GLUCOSE (BG) MONITORING:

- Before meals
- as needed for suspected low/high BG
- 2 hours after correction
- Midmorning
- Mid-afternoon
- Before dismissal
- May use Continuous Glucose Monitor (CGM) in place of finger stick blood sugar monitoring.

INSULIN ADMINISTRATION:

Insulin delivery system: Syringe or Pen or Pump **Insulin type:** Humalog or Novolog or Apidra or Admelog Fiasp

MEAL INSULIN: (Best if given right **before eating**. For small children, can give within 15-30 minutes of the first bite of food-or right after meal)

- Insulin to Carbohydrate Ratio:
Breakfast: 1 unit per _____ grams carbohydrate
Lunch: 1 unit per _____ grams carbohydrate
- Fixed Dose per meal:
Breakfast: Give _____ units/Eat _____ grams of carbohydrate
Lunch: Give _____ units/Eat _____ grams of carbohydrate

CORRECTION INSULIN: (For high blood sugar. Add before **MEAL INSULIN** to **CORRECTION INSULIN** for **TOTAL INSULIN** dose.)

- Use the following correction formula
For pre-meal blood sugar over _____

(BG - _____) ÷ _____ = extra units insulin to provide
- Sliding Scale:
BG from _____ to _____ = _____ units
BG from _____ to _____ = _____ units
BG from _____ to _____ = _____ units
BG from _____ to _____ = _____ units
> _____ = _____ units

SNACK: A snack will be provided each day at: _____
Carbohydrate coverage only for snack (No BG check required):
 No coverage for snack
 1 unit per _____ grams of carb
 Fixed snack dose: Give _____ units/Eat _____ grams of carb

PARENTAL AUTHORIZATION to Adjust Insulin Dose:

- YES NO Parents/guardians are authorized to increase or decrease insulin-to-carb ratio within the following range:
1 unit per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate
- YES NO Parents/guardians are authorized to increase or decrease correction dose with the following range: +/- _____ units of insulin
- YES NO Parents/guardians are authorized to increase or decrease fixed insulin dose with the following range: +/- _____ units of insulin

MANAGEMENT OF LOW BLOOD GLUCOSE:

<p>MILD low sugar: Alert and cooperative student (BG below _____)</p> <ul style="list-style-type: none"><input type="checkbox"/> Never leave student alone<input type="checkbox"/> Give 15 grams glucose; recheck in 15 minutes<input type="checkbox"/> If BG remains below 70, retreat and recheck in 15 minutes<input type="checkbox"/> Notify parent if not resolved<input type="checkbox"/> If no meal is scheduled in the next hour, provide an additional snack with carbohydrate, fat, protein.<input type="checkbox"/> If CGM alarms/reads under LOW LIMIT after 15 minutes of treating a low, student should verify BG with finger stick.	<p>SEVERE low sugar: Loss of consciousness or seizure</p> <ul style="list-style-type: none"><input type="checkbox"/> Call 911. Open airway. Turn to side.<input type="checkbox"/> Glucagon injection IM/SubQ <input type="checkbox"/> _____ <input checked="" type="checkbox"/> 0.50mg<input type="checkbox"/> Notify parent.<input type="checkbox"/> For students using insulin pump, stop pump by placing in "suspend" or stop mode, disconnecting at pigtail or clip, and/or removing an attached pump. If pump was removed, send with EMS to hospital.
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MANAGEMENT OF HIGH BLOOD GLUCOSE: (above _____ mg/dl)

- Sugar-free fluids/frequent bathroom privileges.
- If BG is greater than 300 and it's been 2 hours since last dose, give HALF FULL correction formula noted above.
- If BG is greater than 300 and it's been 4 hours since last dose, give FULL correction formula noted above.
- If BG is greater than _____, check for ketones. Notify parent if ketones are present.
- Child should be allowed to stay in school unless vomiting with moderate or large ketones present.
- If the CGM alarms/reads over HIGH LIMIT, student may give correction bolus according to above instructions

MANAGEMENT DURING PHYSICAL ACTIVITY:

Student shall have easy access to fast-acting carbohydrates, snacks, and blood glucose monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below _____ mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

- Check blood sugar right before physical education to determine need for additional snack.
- If BG is less than _____ mg/dl, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.
- Student may disconnect insulin pump for 1 hour or decrease basal rate by _____.
- For new activities: Check blood sugar before and after exercise only until a pattern for management is established.
- A snack is required prior to participation in physical education.

Student's Name: _____ Date of Birth: _____

NOTIFY PARENT of the following conditions: (If unable to reach parent, call diabetes provider office at _____)

- a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon.
- b. Blood sugars in excess of 300 mg/dl, when ketones present.
- c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

SPECIAL MANAGEMENT OF INSULIN PUMP:

- Contact Parent in event of:
 - Pump alarms or malfunctions
 - Detachment of dressing / infusion set out of place
 - Leakage of insulin
 - Student must give insulin injection
 - Student has to change site
 - Soreness or redness at site
 - Corrective measures do not return blood glucose to target range within _____ hrs.
- Parents will provide extra supplies including infusion sets, reservoirs, batteries, pump insulin, and syringes.

SPECIAL MANAGEMENT CONTINUOUS GLUCOSE MONITORS (CGM): _____ (Brand of CGM)

- Contact Parent in event of: issue with alarms or malfunctions

<p>This student requires assistance by the School Nurse or Trained Diabetes Personnel with the following aspects of diabetes management:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Monitor and record blood glucose levels (as instructed on page 1) <input type="checkbox"/> Respond to elevated or low blood glucose levels <input type="checkbox"/> Administer glucagon when required <input type="checkbox"/> Calculate and give insulin Injections <input type="checkbox"/> Administer oral medication <input type="checkbox"/> Monitor blood or urine ketones <input type="checkbox"/> Follow instructions regarding meals and snacks <input type="checkbox"/> Follow instructions as related to physical activity <input type="checkbox"/> Respond to CGM alarms. Check BG with glucose meter if symptoms do NOT match sensor readings. Treat using Management Plan on page 1. <input type="checkbox"/> Insulin pump management administer insulin, inspect infusion site, contact parent for problems <input type="checkbox"/> Provide other specified assistance: _____ 	<p>This student may independently perform the following aspects of diabetes management:</p> <p>Monitor blood glucose:</p> <ul style="list-style-type: none"> <input type="checkbox"/> in the classroom <input type="checkbox"/> in the designated clinic office <input type="checkbox"/> in any area of school and at any school related event <ul style="list-style-type: none"> <input type="checkbox"/> Monitor urine or blood ketones <input type="checkbox"/> Calculate and give own injections <input type="checkbox"/> Calculate and give own injections with supervision <input type="checkbox"/> Treat hypoglycemia (low blood sugar) <input type="checkbox"/> Treat hyperglycemia (elevated blood sugar) <input type="checkbox"/> Carry supplies for blood glucose monitoring <input type="checkbox"/> Carry supplies for insulin administration <input type="checkbox"/> Carry prescription medication listed in the school DMMP <input type="checkbox"/> Determine own snack/meal content <input type="checkbox"/> Manage insulin pump <input type="checkbox"/> Replace insulin pump infusion set <input type="checkbox"/> Management of CGM (Calibrating, monitoring, and responding to alarms) <input type="checkbox"/> Cell phone is used as CGM receiver
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LOCATION OF SUPPLIES/EQUIPMENT: (Parent will provide and restock all supplies, snacks and low blood sugar treatment supplies.)
 This section will be completed by school personnel and parent:

	Clinic room	With student		Clinic room	With student
Blood glucose equipment	<input type="checkbox"/>	<input type="checkbox"/>	Glucagon kit	<input type="checkbox"/>	<input type="checkbox"/>
Insulin administration supplies	<input type="checkbox"/>	<input type="checkbox"/>	Glucose gel	<input type="checkbox"/>	<input type="checkbox"/>
Ketone supplies	<input type="checkbox"/>	<input type="checkbox"/>	Juice /low blood glucose snacks	<input type="checkbox"/>	<input type="checkbox"/>

*My signature provides authorization for the above Diabetes Mellitus Medical Management Plan.
 I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.*

SIGNATURE of AUTHORIZED PRESCRIBER: _____ **DATE:** _____
 Authorized Prescriber: MD, NP, PA

Name of Authorized Prescriber: _____

Address: _____

Phone: _____

SIGNATURES

I, (Parent/Guardian) _____ understand that all treatments and procedures may be performed by the student and/or Trained Diabetes Personnel within the school, or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by Georgia state law.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____