INDIVIDUALIZED HEALTH CARE PLAN FOR STUDENTS WITH DIABETES
2023-2024 SCHOOL YEAR

To be completed by the Parent:

Students Name: _____ D.O.B.: _____

School: _____

FATHER/GUARDIAN NAME:_____ MOTHER/GUARDIAN NAME:_____

ADDRESS: _____ ADDRESS: _____

EMAIL: _____ EMAIL: _____

CELL PHONE: _____ CELL PHONE: _____

FATHER'S EMPLOYER:_____ MOTHER'S EMPLOYER:_____

WORK PHONE: _____ WORK PHONE: _____

LIST PERSONS TO BE CONTACTED IN CASE OF EMERGENCY WHEN PARENT/GUARDIAN CANNOT BE REACHED

EMERGENCY CONTACTS	
NAME:_____	NAME:_____
PHONE:_____	PHONE:_____
EMAIL: _____	EMAIL: _____
RELATIONSHIP:_____	RELATIONSHIP:_____

Trained unlicensed school personnel: (filled in by school**)**

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Parent/Guardian Signature: _____ Date: _____

To be completed by the School:

This Diabetes Medical Management Plan has been reviewed by:

School Nurse/Health Coordinator Signature: _____ Date: _____

Principal Signature:_____ Date:_____

Before & After Program Coordinator Signature: _____ Date: _____
(If applicable)

Teacher notification provided by:

School Personnel Signature: _____ Date: _____

Date of Plan:_____

Student's Name:_____ Date of Birth:_____

Date of Diabetes Diagnosis: _____ ☐ type 1 ☐ type 2 ☐ Other _____

School:_____ School Phone:_____

Grade: _____ Teacher: _____ Nurse: _____

Physician: _____ Office Phone:_____

Address: _____

CHECKING BLOOD GLUCOSE

Brand/Model of blood glucose meter:_____

Target range of blood glucose: ☐ 70-130 mg/dL ☐ 70-180 mg/dL ☐ Other: _____

Check blood glucose level:

☐ Before breakfast ☐ After breakfast ☐ _____Hours after breakfast ☐ 2 hours after a correction dose

☐ Before lunch ☐ After lunch ☐ _____Hours after lunch ☐ Before dismissal

☐ Mid-morning ☐ Before PE ☐ After PE ☐ Other:_____

☐ As needed for signs/symptoms of low or high blood glucose ☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Fingertip ☐ Forearm ☐ Thigh ☐ Other: _____

Note: The, fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires school nurse or trained diabetes personnel to check blood glucose

☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No Brand/Model:_____

Alarms set for: Severe Low: _____ Low: _____ High: _____

Predictive alarm: Low: _____ High: _____ Rate of change: Low: _____ High: _____

Threshold suspend setting: _____

Additional information for student with CGM

- Confirm CFG results with a blood glucose meter check before taking action on the sensor blood glucose level. If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-Care CGM Skills	Independent?	
The student troubleshoots alarms and malfunctions.	☐ **YES**	☐ **NO**
The student knows what to do and is able to deal with a HIGH alarm.	☐ **YES**	☐ **NO**
The student knows what to do and is able to deal with a LOW alarm.	☐ **YES**	☐ **NO**
The student can calibrate the CGM.	☐ **YES**	☐ **NO**
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ **YES**	☐ **NO**

The student should be escorted to the nurse if the CGM alarm goes off: ☐ **YES** ☐ **NO**

Other instructions for the school health team: _____

_____

HYPOGLYCEMIA TREATMENT

Student's usual symptoms of hypoglycemia (list below):_____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give a quick-acting glucose product equal to _____grams of carbohydrate.

Recheck blood glucose in 10-15 minutes and repeat treatment if blood glucose level is less than _____mg/dL.

Additional treatment: _____

_____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions:

- Position the student on his or her side to prevent choking.
- Give glucagon: ☐ 1 mg ☐ 1/2 mg ☐ Other: _____
  - Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
  - Site for glucagon injection : ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: _____
- Call 911 (Emergency Medical Services) and the student's parents/guardian.
- Contact student's health care provider.

HYPERGLYCEMIA TREATMENT

Student's usual symptoms of hyperglycemia (list below):_____

_____

CHECK:

- ☐ Urine ☐ Blood for ketones every_____ hours when blood glucose levels are above _____mg/dL.
- For blood glucose greater than _____mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _____ mg/dL.
- For insulin pump users: see **Additional information for Students with Insulin Pump.**
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ounces per hour.

Additional treatment for ketones: _____

- Follow physical activity and sports orders. (See **Physical Activity and Sports)**
- If the student has symptoms of a hyperglycemia emergency, Call 911 (Emergency Medical Services) and contact the student's parents/guardians and healthcare provider. Symptoms of hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

INSULIN THERAPY

Insulin delivery device: ☐ Syringe ☐ Insulin pen ☐ Insulin pump

Type of insulin therapy at school: ☐ Adjustable (basal-bolus) Insulin ☐ Fixed Insulin Therapy ☐ No insulin

ADJUSTABLE (Basal-bolus) INSULIN THERAPY

- **Carbohydrate Coverage/Correction Dose:** Name of insulin:_____
- **Carbohydrate Coverage:**

  Insulin-to-Carbohydrate Ratio: ***Breakfast***: 1 unit of insulin per _____grams of carbohydrate
  Lunch: 1 unit of insulin per _____grams of carbohydrate
  Snack: 1 unit of insulin per _____grams of carbohydrate

Carbohydrate Dose Calculation Example
Total Grams of Carbohydrates to Be Eaten = _____ **Units of Insulin** **Correction Factor**

Correction Dose: Blood glucose correction factor (insulin sensitivity factor) = _____
Target blood glucose = _____mg/dL

INSULIN THERAPY (continued)

Correction Dose Calculation Example
<u>Correct Blood Glucose- Target Blood Glucose</u> = _____ Units of Insulin **Correction Factor**

Correction Dose Scale (use instead of calculation above to determine insulin correction dose):

Blood glucose _____ to _____ mg/dL, give _____ units

Blood glucose _____ to _____ mg/dL, give _____ units

Blood glucose _____ to _____ mg/dL, give _____ units

Blood glucose _____ to _____ mg/dL, give _____ units

When to give insulin:

Breakfast

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Other: _____

Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Other: _____

Snack

☐ No coverage for snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Correction dose only: For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.

☐ Other: _____

Fixed Insulin Therapy

Name of insulin:_____

☐ _____ Units of insulin given pre-breakfast daily

☐ _____ Units of insulin given pre-lunch daily

☐ _____ Units of insulin given pre-snack daily

☐ Other: _____

INSULIN THERAPY (continued)

Parental Authorization to Adjust Insulin Dose:

☐ **YES** ☐ **NO** Parents/guardians authorization should be obtained before administering a correction dose.

☐ **YES** ☐ **NO** Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/-_____units of insulin.

☐ **YES** ☐ **NO** Parents/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____units per prescribed grams of carbohydrate, +/- _____grams of carbohydrate.

☐ **YES** ☐ **NO** Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

Student's self-care insulin administration skill

☐ Yes ☐ No	Independently calculates and gives own injections
☐ Yes ☐ No	May calculate/give own injections with supervision
☐ Yes ☐ No	Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision
☐ Yes ☐ No	Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP

Brand/Model of pump:_____ Type of insulin in pump:_____

Basal rates during school: Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____

Other pump instructions: _____

_____

Type of infusion set: _____

Appropriate infusion site(s): _____

☐ For blood glucose greater than ☐ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.

☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Physical Activity

May disconnect from pump for sports activities: ☐ Yes, for _____hours ☐ No

Set a temporary basal rate ☐ Yes, _____% temporary basal for _____ hours ☐ No

Suspend pump use: ☐ Yes, for _____hours ☐ No

Student's Self-Care Pump Skills	Independent?	
Counts carbohydrates	☐ **YES**	☐ **NO**
Calculates correct amount of insulin for carbohydrates consumed	☐ **YES**	☐ **NO**
Administers correction bolus	☐ **YES**	☐ **NO**
Calculates and sets basal profiles	☐ **YES**	☐ **NO**
Calculates and sets temporary basal rate	☐ **YES**	☐ **NO**
Changes batteries	☐ **YES**	☐ **NO**
Disconnects pump	☐ **YES**	☐ **NO**
Reconnects pump to infusion set	☐ **YES**	☐ **NO**
Prepares reservoir, pod and/or tubing	☐ **YES**	☐ **NO**
Inserts infusion set	☐ **YES**	☐ **NO**
Troubleshoots alarms and malfunctions	☐ **YES**	☐ **NO**

OTHER DIABETES MEDICATIONS

Type of Medication ☐ Prescription ☐ Non-Prescription	Name of Medication and Strength		
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given (Dosage)
Form of Medication ☐ Tablet ☐ Capsule ☐ Liquid ☐ Inhalant ☐ Injection ☐ Other _____			Route (ex: oral, nasal)

Type of Medication ☐ Prescription ☐ Non-Prescription	Name of Medication and Strength		
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given (Dosage)
Form of Medication ☐ Tablet ☐ Capsule ☐ Liquid ☐ Inhalant ☐ Injection ☐ Other _____			Route (ex: oral, nasal)

MEAL PLAN

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		_____ **to** _____
Mid-morning snack		_____ **to** _____
Lunch		_____ **to** _____
Mid-afternoon snack		_____ **to** _____

Other times to give snacks and content/amount: _____

_____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): _____

_____

Special event/party food permitted: ☐ Parents/guardian discretion ☐ Student discretion

Student's Self-Care Nutritional Skills		
Independently counts carbohydrates	☐ **YES**	☐ **NO**
May count carbohydrates with supervision	☐ **YES**	☐ **NO**
Requires school nurse/trained diabetes personnel to count carbohydrates	☐ **YES**	☐ **NO**

PHYSICAL ACTIVITY AND SPORTS

A quick-acting source of glucose below must be available at site for physical education activities and sports.

Source of glucose:	☐ Glucose tabs and/or ☐ Sugar-containing juice
Student should eat:	☐ 15 grams ☐ 30 grams of carbohydrate ☐ other: _____
Times to consume:	☐ Before activity ☐ Every 30min during activity ☐ Every 60 min during activity ☐ After physical activity ☐ Other: _____

If most recent blood glucose is less than_____mg/dL, student can participate in physical activity when blood glucose is corrected and above _____mg/dL.

Avoid physical activity when blood glucose is greater than _____mg/dL or if urine/blood ketones are moderate to large.

(Additional information for student on insulin pump is in the insulin section.)

DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follow (e.g., dinner and nighttime): _____

_____

_____

☐ Other: _____

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

_____

Student's Physician/Health Care Provider Date

Acknowledged and received by:

_____

Student's Parent/Guardian Date

SELF-CARRY AND SELF-ADMINISTER DIABETES MEDICATION AGREEMENT
2023-2024 SCHOOL YEAR

To be completed by the Parent and Student:

Student name: _____ Date of Birth: _____

Where will student carry diabetes medication (**required**):_____

Additional diabetes medication will be provided to the school and stored with prescribed medication at specified school location: (**required**):_____

STUDENT

- I will notify school personnel if I am having more difficulty than usual with my diabetes.
- I agree to carry my diabetes medication/supplies with me as listed above. If an emergency arises and I am unable to get to the nurse/school personnel, I will use the diabetes medication as prescribed by the physician and then **immediately** inform a nurse/school personnel.
- I agree to use my diabetes medication/supplies in a responsible manner, in accordance with the physician's orders. I understand my diabetes signs, symptoms, and treatment plan reviewed by my physician and parent(s)/guardian(s) and understand to use my diabetes medication/supplies as prescribed by my physician.
- I agree to never share my diabetes medication/supplies with another person as this is dangerous. If I do this may result in disciplinary action.

Student Signature: _____ Date: _____

PARENT/GUARDIAN

- I agree to see that my child carries his/her diabetes medication/supplies as prescribed, and that it is properly labeled and is not expired.
- I understand that I will provide the school with an additional diabetes medication/supplies to store at school along with any prescribed medication(s) from the physician treatment plan.
- I have reviewed with my child his/her diabetes signs, symptoms and treatment plan including the usage of the self-carry diabetes medication/supplies.
- I agree to regularly review with my child the proper use of his/her diabetes medication/supplies when at school.
- I agree to regularly review the status of my child's diabetes with the physician and to notify the physician when my child is having more difficulty than usual.
- I understand if my child shares medication/supplies with other students it may result in disciplinary actions.
- My child has demonstrated to his/her physician and the school, nurse, if available, the skill level necessary to self-administer the prescription medication, including the use of any device required to administer the medication in case an emergency arises and they are unable to get to a school personnel/nurse.
- The self-administration is done in compliance with the prescription or written authorization for my child to self-administer the medicine while on school property or at a school-related event or activity.
- I understand that such self-administration must be done in compliance with the prescription or written instructions of my child's physician. Additionally, I have provided a written and signed statement from my child's physician that states:
    1. The student has a diabetes and is capable of self-administering the prescription medicine;
    2. The name and purpose of the medicine; the prescribed dosage of the medicine; the times or circumstances which the medicine may be administered; and the duration for which the medicine is prescribed.
- This is in effect for the current school year only unless revoked by the physician or the student, parent(s)/guardian(s) fails to meet all the above safety contingencies.

Parent Signature: _____ Date: _____