# INDIVIDUALIZED HEALTH CARE PLAN FOR STUDENTS WITH DIABETES
# 2024-2025 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: ___________________

*To be completed by the Physician:*



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: ________________________________________________________________________________

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## 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.

*To be completed by the Physician:*



## 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.

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## 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**<br>**Correction Factor** |

**Correction Dose:** Blood glucose correction factor (insulin sensitivity factor) = __________
Target blood glucose = _________mg/dL

*To be completed by the Physician:*



**INSULIN THERAPY** (continued)

| Correction Dose Calculation Example |
|---|
| <u>**Correct Blood Glucose- Target Blood Glucose**</u> = ___________ **Units of Insulin**<br>**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<br>☐ 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<br>☐ Tablet ☐ Capsule ☐ Liquid ☐ Inhalant ☐ Injection ☐ Other ____________________ | | | Route (ex: oral, nasal) |

| Type of Medication<br>☐ 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<br>☐ Tablet ☐ Capsule ☐ Liquid ☐ Inhalant ☐ Injection ☐ Other ____________________ | | | Route (ex: oral, nasal) |

*To be completed by the Physician:*



## 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<br>☐ 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
# 2024-2025 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.<br>• 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.<br>• 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.<br>• 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.<br>**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.<br>• I understand that I will provide the school with additional diabetes medication/supplies to store at school along with any prescribed medication(s) from the physician's treatment plan.<br>• I have reviewed with my child his/her diabetes signs, symptoms, and treatment plan including the usage of the self-carry diabetes medication/supplies.<br>• I agree to regularly review with my child the proper use of his/her diabetes medication/supplies when at school.<br>• 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.<br>• I understand if my child shares medication/supplies with other students it may result in disciplinary actions.<br>• 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.<br>• 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.<br>• 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:<br>1. The student has diabetes and is capable of self-administering the prescription medicine.<br>2. The name and purpose of the medicine; the prescribed dosage of the medicine; the times or circumstances in which the medicine may be administered; and the duration for which the medicine is prescribed.<br>• 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.<br>**Parent Signature:** _______________________________________________ **Date:** _____________________ |