Diabetes Management Plan and School Treatment Authorizations

(School Year: July 1st – June 30th)**for the School Year** (or dates provided)**:**

> This plan outlines the diabetes management for children and adolescents to be used at home or in any community or school setting. This plan is *in accordance with CT State Law and Regulations 10-212a, Administration of Medication in School*

Part 1: To be completed by <u>parent/guardian</u> and reviewed with diabetes provider

Name: _____ DOB: _____

Diabetes Center: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Other health conditions: _____

Diabetes Medication at home: _____ ☐ Has Medical Alert Bracelet

Self-care skills
BG= Blood Glucose

	N/A	Independent	May require some help or supervision	Requires direct assistance by nurse or trained staff
BG monitoring: times, technique, and communication	☐	☐	☐	☐
Knows meaning of BG results and what to do	☐	☐	☐	☐
Draw up or set pen for correct insulin dose:				
• For amount for carbohydrates consumed	☐	☐	☐	☐
• Based on sliding scale	☐	☐	☐	☐
Insulin injection technique	☐	☐	☐	☐
Count carbohydrates	☐	☐	☐	☐
Pump Specific				
Calculate and administer correction bolus	☐	☐	☐	☐
Calculate and set temporary basal rate	☐	☐	☐	☐
Troubleshoot alarms and malfunctions	☐	☐	☐	☐
Disconnect pump	☐	☐	☐	☐
Reconnect pump to infusion set	☐	☐	☐	☐
Change batteries	*These skils require some degree of student competence &/or family responsibility* ☐	☐	☐	■
Prepare reservoir and tubing	☐	☐	☐	■
Calculate and set basal profiles/rates	☐	☐	☐	■
Insert tubing set	☐	☐	☐	■
Change site	☐	☐	☐	■

Blood Glucose Monitoring
Student's BG goal : _____ to _____ Mg/dl

Check BG at times checked below AND for signs & symptoms of Hyper or Hypo Glycemia

☐ Before meals   ☐ Before P.E. or Recess   ☐ Before standardized or major exam
☐ Before snacks   ☐ After P.E. or Recess   ☐ During field trip / after hours activities
☐ Mid-morning   ☐ Before Dismissal   ☐ Other:

- Clean hands or site as needed
- Use only fingers if low blood sugar suspected
- No alcohol for skin preparation
- Change lancet at least daily

When to call for help: Call parent/guardian and/or diabetes provider if needed:

- Persistent BG < 70 despite prescribed treatment
- Suspected pump or insertion site failure
- 2 consecutive BG > 250, 2 hrs apart &/or moderate to large ketones

- Daily episodes of BG below 70 or above 250 for 3 consecutive school days
- Questions or concerns

Part 2: Insulin Therapy: To be completed by MD /DO/APRN/PA

➢ Parent/guardian is authorized to make or direct all changes of pump settings throughout the school year
➢ RN may increase or decrease insulin injection doses +/- 5 units in collaboration with parent/guardian for temporary changes in condition, such as illness. Changes that persist greater than 5 school days require an updated medical authorization signed by provider and parent

PUMP: Settings stored in pump, follow pump model procedures   Type/Model:

Insulin Type: ☐ Humalog / Novolog / Apidra   ☐ Other:

Management Options for Students who use Continuous Subcutaneous Insulin Infusion (CSII)

☐ Meal bolus and correction for   ☐ Lunch and Snacks ☐ Lunch only ☐ Dinner (field trips or after hours)
☐ Meal bolus only for snacks
☐ Correction dose PRN for BG > _____ Mg/dL (Do not give within 2-3 hours of another bolus)
☐ Other:

Planned /Sports Activities: ☐ May disconnect from pump during activity < 1hr ☐ Suspend pump during activity (< 1hr)
   Set temporary basal rate at: or ☐ per student if independent ☐ No adjustment necessary
      ➢ *DO NOT OVERRIDE PUMP WITHOUT AUTHORIZATION* (protects against overcorrection and hypoglycemia)

Assess Pump or Site Failure: For 2 consecutive BG > 250, 2 hours apart &/or moderate to large ketones
➢ Back-up insulin by syringe or pen must be kept in school to use if pump or site failure occurs:
• For site failure only, use pump to determine insulin doses
• For pump failure, administer Insulin injection by ☐ Sliding Scale **OR** ☐ Correction Factor   *As stated below*
   o Before meals and/or every _____ hours

INJECTIONS   Insulin Type: ☐ Humalog / Novolog / Apidra | ☐ Other: | ☐ Syringe / Insulin Pen

Management Options for Students who use Multiple Dose Insulin Injections (select those that apply)

☐ Fixed insulin dose at home (amount/times): _____
☐ Fixed insulin dose required at school (amount/times): _____
☐ Carbohydrate goals for snacks/meals, *see below*
☐ Sliding scale for meals, *carbohydrate counting if indicated below*
☐ Carbohydrate Coverage using insulin:carb ratio with ☐ Sliding Scale **OR** ☐ Correction Factor (see formula below)

Carbohydrate Goals: *may be adjusted by parent/guardian*

Breakfast:	AM Snack:	Lunch:	PM Snack:	Dinner:
Gym/recess:	Field trip/After hours:			

OR

Carbohydrate Coverage (insulin:carb ratio), *Use for Pump Failure* ☐ Before Meals ☐ Before Snacks

Do not use sliding scale with snacks

Insulin: Carb Ratio Formula | 1 | unit of insulin per: | | grams of carbohydrates

AND

☐ **Sliding Scale**: *may be used with or without carb coverage*   ☐ **Calculate Correction (insulin sensitivity) Factor**

BG Range (mg/dL)	Give SC insulin	
≤ _____	_____	units
_____ to _____	_____	units
_____ to _____	_____	units
_____ to _____	_____	units
_____ to _____	_____	units
_____ to _____	_____	units
_____ to _____	_____	units
_____ to _____	_____	units

OR   Target BG: _____ Correction factor: _____

$$\frac{\text{Current BG} - \text{Target BG}}{\text{Correction Factor}} = \underline{\hspace{2cm}} \text{ Units of insulin}$$

Round to the nearest half or whole unit

Coverage Guidelines for All Meals:
• If BG< 70, follow hypoglycemia protocol
• If BG ≥70 cover with insulin and send to meal
• If BG remains <70 may send to meal and cover with insulin after student eats

Part 3:

Hypoglycemia Management (BG < 70mg/dL)

Usual symptoms include: dizziness, confusion, sweating, shaky, hunger, fatigue (circle any that are commonly specific to student) or other: _____

➤ Location and nurse involvement for hypoglycemia treatment is based on severity of episode and student's self-management skills &/or IHCP, standard management options include:
- Give 12-16 gms of fast-acting carbohydrate (4oz juice, 3-4 glucose tabs, etc.)
  - ○ Give 1 tube of glucose gel (15gms) between cheek and gum if symptoms require urgent effect
- Re-test BG in 20 minutes (wait 30 minutes if using pump) to confirm level > 70mg/dL, if not repeat with rapid-acting carbs or lunch/meal (see meal coverage guidelines)
  - ○ *Repeat BG may not be indicated for students who can verbalize improvement of symptoms*

Administer glucagon : ☐ 0.5mg IM/SC **or** ☐ 1mg IM/SC in thigh or deltoid, can inject through clothes: **PRN for severe and symptomatic hypoglycemia, including unable to swallow, seizure activity, or unconsciousness; and Call 911**
➤ *Parent guardian responsible for providing glucagon to school if ordered*
➤ Glucagon is to be administered by school nurse or authorized school staff (as amended in Section 10-212a)
➤ *Field Trip management (including glucagon option) to be assessed by school nurse in collaboration with parent or guardian and diabetes provider (as needed) on an individual basis and in consideration of EMS response times*

Hyperglycemia (BG> 250mg/dL) & Ketones Management

- Check urine or blood for ketones if 2 consecutive BG > 250mg/dL &/or has nausea or vomiting
  - ○ If ketones negative, trace, or small and feels well, continue plan and return to class or gym
  - ○ If ketones are moderate or large &/or 2 consecutive BG >250mg/dL:
    - ▪ call parent/guardian, if not available, call diabetes provider for insulin dose
    - ▪ Follow pump protocol to assess for pump or site failure
    - ▪ Hold P.E. or recess until ketones resolved
- Encourage drinking sugar -free (0 carbohydrate) beverage, preferably water, 8 oz every 30-60 minutes
- Do not withhold food

☐ Other:

	Printed or stamped, include phone and fax:
Prescriber's Signature: _____	
Date: _____	

Parent/Guardian Authorization: I hereby request that the above ordered medication and diabetes management procedures be administered by school personnel. I also give my consent for the exchange of information between the prescribing health care provider and school nurse, as needed for the safe implementation of this plan in school.

➤ *Parent/Guardian responsible for providing all diabetes medical supplies and snacks/juice to school*
➤ **School Delay:** Parent/Guardian must notify the school nurse/responsible staff of any change in schedule or insulin

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Use Only ☐ See attached IHCP addendum

Name: _____ D.O.B. _____ Date: _____

Addendum to Diabetes Management Plan and School Treatment Authorizations: for changes that persist greater than 5 school days and require medical provider authorization OR for extended field trip

Management Options for Students who use Continuous Subcutaneous Insulin Infusion (CSII)

☐ Meal bolus and correction for ☐ Lunch and Snacks ☐ Lunch only ☐ Dinner (field trips or after hours)

☐ Meal bolus only for snacks

☐ Correction dose PRN for BG > _____ Mg/dL (Do not give within 2-3 hours of another bolus)

☐ Other:

Planned /Sports Activities: ☐ May disconnect from pump during activity < 1hr ☐ Suspend pump during activity (< 1hr)

Set temporary basal rate at: _____ or ☐ per student if independent ☐ No adjustment necessary

➢ *DO NOT OVERRIDE PUMP WITHOUT AUTHORIZATION* (protects against overcorrection and hypoglycemia)

Assess Pump or Site Failure: For 2 consecutive BG > 250, 2 hours apart &/or moderate to large ketones

➢ Back-up insulin by syringe or pen must be kept in school to use if pump or site failure occurs:

• For site failure only, use pump to determine insulin doses

• For pump failure, administer Insulin injection by ☐ Sliding Scale **OR** ☐ Correction Factor ***As stated below***

  o Before meals and/or every _____ hours

INJECTIONS **Insulin Type:**	Humalog / Novolog / Apidra	Other:		Syringe / Insulin Pen

Management Options for Students who use Multiple Dose Insulin Injections (select those that apply)

☐ Fixed insulin dose at home (amount/times): _____

☐ Fixed insulin dose required at school (amount/times): _____

☐ Carbohydrate goals for snacks/meals, *see below*

☐ Sliding scale for meals, *carbohydrate counting if indicated below*

☐ Carbohydrate Coverage using insulin:carb ratio with ☐ Sliding Scale **OR** ☐ Correction Factor (see formula below)

Carbohydrate Goals: *may be adjusted by parent/guardian*

Breakfast: _____ AM Snack: _____ Lunch: _____ PM Snack: _____ Dinner: _____

Gym/recess: _____ Field trip/After hours: _____

OR

Carbohydrate Coverage (insulin:carb ratio), *Use for Pump Failure* ☐ Before Meals ☐ Before Snacks

Do not use sliding scale with snacks

Insulin: Carb Ratio Formula [1] unit of insulin per: [ ] grams of carbohydrates

---

AND

☐ **Sliding Scale***: may be used with or without carb coverage*

BG Range (mg/dL)   Give SC insulin

≤ _____   _____ units

_____ to _____   _____ units

_____ to _____   _____ units

_____ to _____   _____ units

_____ to _____   _____ units

_____ to _____   _____ units

_____ to _____   _____ units

☐ **Calculate Correction (insulin sensitivity) Factor**

OR   Target BG: _____ Correction factor: _____

$$\frac{\text{Current BG} - \text{Target BG}}{\text{Correction Factor}} = \underline{\hspace{2cm}} \text{ Units of insulin}$$

Round to the nearest half or whole unit

Coverage Guidelines for All Meals:

• If BG< 70, follow hypoglycemia protocol

• If BG ≥70 cover with insulin and send to meal

• If BG remains <70 may send to meal and cover with insulin after student eats

---

Administer glucagon : ☐ 0.5mg IM/SC **or** ☐ 1mg IM/SC **PRN for severe and symptomatic hypoglycemia, including unable to swallow, seizure activity, or unconsciousness; Call 911 if administered**

Prescriber's Signature: _____ **Date:** _____

Parent/Guardian Authorization: I hereby request that the above ordered medication and diabetes management procedures be administered by school personnel. I also give my consent for the exchange of information between the prescribing health care provider and school nurse, as needed for the safe implementation of this plan in school.

Parent Signature: _____ **Date:** _____