Berkeley County Schools
Diabetes Medical Management Plan

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant staff and copies kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.
A new form must be submitted each school year, dated after July 1st.
A new form or amended order must be submitted for any changes to this plan.

Date of Plan: _____________ School Year: _______________
This plan is valid for the current school year (includes extended school year/summer programs)

Student Information

Student's Name: ______________________________________ Date of Birth: __________________
School: ______________________________________ School Phone Number: __________________
Grade: ____________ Home Room Teacher: ____
School Nurse: __________________________________ Phone: ______________________________

Contact Information

Parent/Guardian 1: ____________________________________ Phone Number: __________________
Address: _____________________________________ Email: __________________________________

Parent/Guardian 2: ____________________________________ Phone Number: __________________
Address: ______________________________________ Email: __________________________________

Student's Physician/Heath Care Provider (print): ____
Address: ____
Office Number: ___________________________ Emergency Number: ___________________________
Fax Number: ___________________________ Email: ____

Parent Authorization/Contract

- I give permission for the school nurse to contact the prescribing physician as needed.
- I consent to the release of the information contained in the plan to all school staff members who have responsibility for my child to maintain my child's health and safety.
- I understand that I must supply the school with all required diabetic supplies, juice and snacks.
- I understand that I must notify the school for any changes in my child's medical care.

____
Parent/Guardian Name (Print)

____________________________________ ______________________
Parent/Guardian (Signature) Date

Checking Blood Glucose

Target Range of Blood Glucose: ____________-_______________

Check Blood Glucose Levels: (check all that apply)

- ❑ Before Breakfast
- ❑ Before Lunch
- ❑ Before Snacks
- ❑ Before PE
- ❑ Before Bus Ride
- ❑ As needed for signs/symptoms of low or high blood glucose
- ❑ As needed for symptoms of illness

Student's Self-Care Blood Glucose Testing Skills: (check one)

- ❑ Independently checks own blood glucose
- ❑ May check own blood glucose with supervision
- ❑ Requires a 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 _________________
Threshold suspend setting : ____

Student's Self-Care CGM Skills: (check all that apply)

- ❑ The student troubleshoots alarms and malfunctions.
- ❑ The student knows what to do and is able to deal with a high alarm.
- ❑ The student knows what to do and is able to deal with a low alarm.
- ❑ The student can calibrate the CGM.
- ❑ The student knows what to do when the CGM indicates a rapid rise or fall in the blood glucose level.

Hypoglycemia

Students usual symptoms: ____

- If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _______ mg/dl, give a quick-acting glucose product equal to 15 grams of carbohydrate.
- Recheck blood glucose in 15 minutes and repeat treatment if blood glucose is less than ____ mg/dl.
- Provide a carbohydrate/protein snack once glucose returns to normal range.

Additional Treatment: ____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsion (jerking movement):

- Position on his/her side to prevent choking
- Administer Emergency Medication

Injectable Route (Glucagon, Glucagen, Gvoke)	OR	**Nasal Route (Baqsimi)**
Dose: ____1 mg ____ 0.5 mg		Dose: ___ 3 mg
Route: ____subcutaneous ____Intramuscular		Route: ___ Intranasal
Site: ____ buttocks ____ arm ____thigh ____ lower abdomen		Site: ____ Nose

- Call 911, parents/guardians, and health care provider
- If on insulin pump, STOP pump by any of the following methods:
  - Place pump in “suspend” or “stop mode”
  - Disconnect pump at site
- Send pump with EMS to hospital

Hyperglycemia

Student’s usual symptoms: ____

- Check urine for ketones every ____ hours when blood glucose levels are above ____ mg/dL.
- For blood glucose greater then ______ mg/dL AND at least ______ hours since last insulin dose, give correction dose of insulin (see correction orders).
- Notify parents/guardians if blood sugar is over ______ mg/dL
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar containing drinks
- If student has symptoms of a hyperglycemia emergency, call 911 and contact parents/guardians and health care provider. Symptoms of a 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.

Additional treatment for ketones: ____

Insulin Therapy

Insulin Delivery Device:

- ❑ Syringe
- ❑ Pen
- ❑ Insulin Pump: Brand/Model ___________________________________

Type of Insulin Therapy: Name of Insulin ______________________________

- ❑ Adjustable (basal-bolus)
- ❑ Fixed Insulin Therapy
- ❑ Long-Acting Insulin Therapy
- ❑ No Insulin

Insulin to Carbohydrate Dose

❑ Breakfast	_________ unit of insulin	Per _______ gm of carbohydrate
❑ Lunch	_________ unit of insulin	Per _______ gm of carbohydrate
❑ AM Snack	_________ unit of insulin	Per _______ gm of carbohydrate
❑ PM Snack	_________ unit of insulin	Per _______ gm of carbohydrate

Correction Dose Calculation

Current Blood Glucose – Target Blood Glucose / Correction Factor =	
Target Blood Sugar ______________	Correction Factor ______________

Fixed Insulin Therapy:

- ❑ ______ Units of Insulin given pre-breakfast daily
- ❑ ______ Units of Insulin given pre-lunch daily
- ❑ ______ Units of Insulin given pre-snack daily

Sliding Scale Insulin Therapy

Blood Glucose	To	Give Units
Blood Glucose	To	Give Units
Blood Glucose	To	Give Units
Blood Glucose	To	Give Units
Blood Glucose	To	Give Units
Blood Glucose	To	Give Units
Blood Glucose	To	Give Units
Blood Glucose	To	Give Units
Blood Glucose	To	Give Units
Blood Glucose	To	Give Units

Student's Insulin Administration Skills: (check all that apply)

- ❑ Independently counts carbohydrates
- ❑ Independently calculates correct amount of insulin for carbohydrate consumed
- ❑ Independently calculates correction dose
- ❑ Independently gives own injections
- ❑ May calculate/give own injections with supervision
- ❑ Requires school nurse to calculate dose and student can give own injection with supervision
- ❑ Requires school nurse to calculate dose and give the injection

Insulin Pump Information

Brand/Model of pump: ___________________________ **Type of insulin pump:** ___________________

Basal Rates during school: Time: _______ Basal rate: ________ Time: _____ Basal rate: _______

Time: _______ Basal rate: ________ Time: _____ Basal rate: _______

Type of Infusion set: ____

Pump Malfunction:

- ❑ 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: give insulin by syringe or pen. Notify parents/guardians.
- ❑ For suspected pump failure: give insulin by syringe or pen. Notify parents/guardians.

Physical Activity:

- ❑ May disconnect pump for sports activities for _____ hours
- ❑ May suspend pump use for sports activities for _____hours

Other Pump Instructions: ____

Student's Self-Care Pump Skills (check all that apply)

- ❑ Counts carbohydrates
- ❑ Calculates correct amount of insulin for carbohydrate consumed
- ❑ Administers correction bolus
- ❑ Disconnects pump
- ❑ Reconnects pump infusion set
- ❑ Troubleshoots alarms and malfunctions

Physical Activity and Sports

A quick-acting source of glucose such as ___ glucose tabs and/or ____ sugar-containing juice must be available at the site of physical educations activities and sports.

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 and/or if urine ketones are moderate to large.

Disaster Plan

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

- ❑ Continue to follow orders per Diabetes Medical Management Plan
- ❑ Additional insulin orders as follows (e.g. dinner and nighttime):

  ____
  ____
  ____

Approval of Diabetes Management Plan

____ _______________________________

Student's Physician/Health Care Provider (signature) Date

Acknowledged and Received By:

____ _______________________________

School Nurse (signature) Date