

# Diabetes Management Plan and School Treatment Authorizations

( School Year: July 1<sup>st</sup> – June 30<sup>th</sup> )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 parent/guardian 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knows meaning of BG results and what to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Draw up or set pen for correct insulin dose:				
• For amount for carbohydrates consumed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Based on sliding scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin injection technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Count carbohydrates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pump Specific</b>				
Calculate and administer correction bolus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calculate and set temporary basal rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Troubleshoot alarms and malfunctions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disconnect pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reconnect pump to infusion set	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change batteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare reservoir and tubing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calculate and set basal profiles/rates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insert tubing set	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*These skills require some degree of student competence &/or family responsibility*

### 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       Other:  
 Mid-morning       Before Dismissal

- 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 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

**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 (**as stated below**) by  Sliding Scale OR  Correction Factor
  - Before meals and/or every \_\_\_\_\_ hours

**INJECTIONS** Insulin Type:  Humalog  Novolog  Apidra  Other:  
 Delivery Device:  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, fixed insulin dose at home or in school
- Sliding scale for meals, no carbohydrate counting or coverage
- Carbohydrate Coverage using insulin:carb ratio with  Sliding Scale OR  Correction Factor (see formula below)

**Carbohydrate Goals** (for fixed insulin doses or as a guideline for individual students)

Breakfast:	AM Snack:	Lunch:	Afternoon Snack:
Dinner:	Other:		

**OR**

**Carbohydrate Coverage** (insulin:carb ratio)  Before Snacks  Before Meals

<p><b>Insulin: Carb Ratio Formula</b> 1 unit of insulin per _____ grams of carbohydrates <b>AND</b> (select one)</p>											
<p><input type="checkbox"/> <b>Sliding Scale:</b> may be used with or without carb coverage</p> <table border="0"> <tr> <td style="text-align: center;">BG Range (mg/dL)</td> <td style="text-align: center;">Give SC insulin</td> </tr> <tr> <td style="text-align: center;">_____ ≤ _____</td> <td style="text-align: center;">_____ units</td> </tr> <tr> <td style="text-align: center;">_____ to _____</td> <td style="text-align: center;">_____ units</td> </tr> <tr> <td style="text-align: center;">_____ to _____</td> <td style="text-align: center;">_____ units</td> </tr> <tr> <td style="text-align: center;">_____ to _____</td> <td style="text-align: center;">_____ units</td> </tr> </table>	BG Range (mg/dL)	Give SC insulin	_____ ≤ _____	_____ units	_____ to _____	_____ units	_____ to _____	_____ units	_____ to _____	_____ units	<p><input type="checkbox"/> <b>Calculate Correction (insulin sensitivity) Factor</b></p> <p>Target BG: _____ Correction factor: _____</p> <p style="text-align: center;"><b>Correction factor formula</b></p> $\frac{\text{Current BG} - \text{Target BG}}{\text{Correction Factor}} = \text{Units of insulin}$
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<p><b>Meal Coverage Guidelines:</b></p> <ul style="list-style-type: none"> <li>• If BG &lt; 70, follow hypoglycemia protocol, re-check in 20 min</li> <li>• If BG ≥ 70 cover with insulin and send to lunch If</li> <li>• If BG remains &lt;70 may send to lunch and cover with insulin after student eats</li> </ul>											

### 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 demonstrate symptoms as a guide to re-check BG

**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**

- Parent guardian responsible for providing glucagon to school if ordered
- Field Trip management (including glucagon option) to be assessed by school nurse in collaboration with parent/guardian and diabetes provider (as needed) on an individual basis and in consideration of EMS response times

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

- Check urine 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: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed or stamped, include phone and fax:

**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: \_\_\_\_\_

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

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 Before meals and/or every \_\_\_\_\_ hours

**INJECTIONS**    **Insulin Type:**  Humalog     Novolog     Apidra     Other: \_\_\_\_\_  
**Delivery Device:**  Syringe     Insulin Pen

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**OR**

**Carbohydrate Coverage** (insulin:carb ratio)  Before Snacks     Before Meals

**Insulin: Carb Ratio Formula**    1 unit of insulin per \_\_\_\_\_ grams of carbohydrates **AND** (select one)

<input type="checkbox"/> <b>Sliding Scale:</b> <i>may be used with or without carb coverage</i> <u>BG Range (mg/dL)</u> _____ ≤ _____ units _____ to _____ units _____ to _____ units _____ to _____ units	<b>OR</b>	<input type="checkbox"/> <b>Calculate Correction (insulin sensitivity) Factor</b> Target BG: _____ Correction factor: _____  <u>Correction factor formula</u> $\frac{\text{Current BG} - \text{Target BG}}{\text{Correction Factor}} = \text{Units of insulin}$
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<b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	<b>Printed or stamped, include phone and fax:</b>
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**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 Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_