

Elko County School District Student Health Services
Diabetes Medical Management Plan

Date of Plan: _____ Type of Diabetes: Type 1 Type 2 Pre-diabetes

Student: _____ Date of Birth: _____

This student is independent in self-managing **all aspects** of his/her diabetes care and does not need routine supervision or assistance from school personnel. **Diabetes orders provided by the licensed healthcare provided in this document will be used as "information only" for EMS responders in the event of a 911 call. This student will be escorted to the health office for parent contact and/or emergency assistance if he/she is experiencing symptoms or reports a blood glucose reading outside of normal parameters.**

OR

This student is NOT independent in self-managing all aspects of his/her diabetes care. I authorize the School Nurse, in collaboration with the parent/guardian, to determine the level of supervision and/or assistance if he/she is experiencing symptoms or reports a blood glucose reading outside of normal parameters.

BLOOD GLUCOSE TESTING

Target range of blood glucose: ____ mg/dL to ____ mg/dL

Test blood glucose level: If symptomatic Before meals Before exercise

Other: _____

Student should not exercise if BG is below ____ mg/dL or above ____ mg/dL

Continuous Glucose Monitor (CGM)? YES NO (Family must also provide school with glucometer.

CGM results will be confirmed with glucometer before taking action on sensor glucose levels. If student has symptoms of hypoglycemia, fingertip blood glucose level will be checked regardless of CGM level.) *The Dexcom G5 is approved for insulin dosing based on glucose values. Correction doses can be determined based on the CGM if the sensor glucose value is between 80-250 and there are no double arrows up or down. In addition, the parent/guardian must sign below verifying they are responsible for calibrating the CGM at home and approve the school personnel or school nurse to dose from the CGM.

HYPOGLYCEMIA TREATMENT

If blood glucose is below 70 and/or student has symptoms of hypoglycemia:

- ✓ Immediately give 15 grams of fast acting carbohydrate
- ✓ Recheck blood glucose in 15 minutes
- ✓ If blood glucose is less than 70 mg/dl, repeat 15 grams of fast acting carbohydrate
- ✓ Student may return to class if blood glucose within target range and student is feeling better
- ✓ Provide protein snack if a meal is not scheduled within the next 30 minutes

If blood glucose remains below 70 after administering 3 cycles of fast acting carbohydrate, student will require immediate parent/ guardian pick-up. 911 will be called if student is unable to eat or drink, is unconscious, unresponsive, or is having seizure activity.

Glucagon will be administered as ordered for severe hypoglycemia: unconscious, semiconscious or seizing.

Glucagon Ordered? Yes No If yes, please complete the following: 1mg 0.5mg

911 will be called if glucagon is administered.

HYPERGLYCEMIA TREATMENT

If blood glucose is above 250:

- ✓ Administer insulin per correction dose orders via pump. If using insulin pen or syringe, it must be at least 3 hours since last insulin dose before giving correction dose.
- ✓ Allow liberal bathroom privileges and encourage student to drink water.
- ✓ Contact parent. If student is not symptomatic, they may remain in school.

Individual orders: _____

INSULIN ADMINISTRATION

1. Insulin to Carbohydrate Ratio (I:C): ____ unit for every ____ grams of carbohydrate before meals or snacks
2. Correction Dose: ____ unit for every ____ mg/dl for blood sugars above ____ mg/dl

Insulin prescribed for school: Apidra Humalog Novolog Other: _____

Delivery Device: Syringe Insulin pen Insulin pump, type: _____

Carbohydrates and Insulin Dosage to be done at: Breakfast Snack Lunch Other: _____

Bolus for carbohydrates should occur immediately prior to lunch/snack unless otherwise specified.

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If using insulin pump, carbohydrate ratio and correction dose are calculated by pump. These doses are provided as information for special circumstances. Basal insulin for pump use:

_____ am/pm : _____ units per hour; _____ am/pm : _____ units per hour; _____ am/pm : _____ units per hour
_____ am/pm : _____ units per hour; _____ am/pm : _____ units per hour; _____ am/pm : _____ units per hour

*If pump malfunctions, School Nurse or Parent may give insulin according to Insulin to Carbohydrate Ratio and/or Correction Factor by injection.

Healthcare Provider Name (please print): _____

Address: _____

Phone: _____ Fax: _____

Healthcare Provider Signature: _____

THIS ORDER IS VALID FOR ONE CALENDAR YEAR

Consent and Request for Nursing Services and Medication Assistance During School Hours:

All medication, supplies (including snacks), and equipment required to provide the student with the above nursing services and/or medication will be provided to Elko County School District by the parent/guardian of the child and the undersigned parent/guardian agrees to assume all responsibility for maintaining the supply of medication. **Immediate parent pick up will be required for students who do not have functioning equipment or supplies necessary to provide diabetes management.**

The undersigned parent/guardian hereby requests Elko County School District to assist and supervise the above named student in diabetes care and management and in taking the above described medication, and consents to such assistance and supervision during the school day. In addition, the parent/guardian gives permission to the School Nurse to exchange confidential information, relative to the Diabetes Medical Management Plan as above, with the undersigned physician/healthcare provider. The undersigned parent/guardian agrees to hold the Elko County School District, the Board of Trustees of the District, and all agents of the District harmless from any liability for their participation in assisting and supervising the above named student in following the Diabetes Medical Management Plan.

Carbohydrate/Menu Information:

If your child will be eating school-prepared meals, carbohydrate calculations are based on the most current menus provided by Elko County School District Nutrition Services. Food substitutions and other variables could alter the carbohydrate ratio set forth regarding calculations that are required for your child's diabetes management. Parent/guardians are responsible to provide carbohydrate information for all foods provided from home.

Parent/Guardian Signature: _____ Date: _____

Emergency Contact Information

Name: _____ Relationship: _____

Telephone: Home _____ Work: _____ Cell: _____

Name: _____ Relationship: _____

Telephone: Home _____ Work: _____ Cell: _____

Name: _____ Relationship: _____

Telephone: Home _____ Work: _____ Cell: _____