

Place Child's
Picture Here

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR and START FROM THE TIME IT'S SIGNED BY THE PHYSICIAN AND PARENT/GUARDIAN****

Diabetes Action/Management Plan for a student without an Insulin Pump

School Year: _____ Grade/Class: _____

Student's Name: _____ Date of birth: _____

Address: _____ City: _____ Zip: _____

Physician Name (Printed): _____ Physician Phone: _____

Emergency Contact Information

1. Parent/Guardian: _____ Phone: _____
2. Emergency Contact: _____ Phone: _____
3. Emergency Contact: _____ Phone: _____

NOTIFICATION TO PARENT/GUARDIAN FOR THE FOLLOWING:	Low Blood Glucose: < ____mg/dl	High Blood Glucose: > ____mg/dl
Continuous Glucose Monitoring (CGM): See continuous glucose monitoring orders <input type="checkbox"/>		
Hypoglycemia (low blood sugar) Mild/Moderate Treatment: <input type="checkbox"/> less than 70 mg/dl <input type="checkbox"/> less than ____mg/dl Follow Rule of 15: Treat with 15 gm of carbohydrate, wait 15 minutes, check blood glucose level and repeat if needed. <input type="checkbox"/> Treat with 2-4 Glucose Tabs <input type="checkbox"/> 4 ounces juice <input type="checkbox"/> Glucose gel (use finger, place between cheek and gum) <input checked="" type="checkbox"/> Student choice of 15 gm snack from home. <input type="checkbox"/> If no meal or snack within the next hour, give a 15-gram snack. NOTIFY PARENT/GUARDIAN IF BLOOD GLUCOSE < ____mg/dl		
<u>Hypoglycemia Severe Symptoms with loss of consciousness/seizures:</u> Call 911/Administer Glucagon, Gvoke or Baqsimi	Glucagon: <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg Gvoke: <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg Baqsimi: <input type="checkbox"/> 3 mg	Physician Order: Intramuscular: <input type="checkbox"/> Arm <input type="checkbox"/> Buttocks <input type="checkbox"/> Thigh Subcutaneous: <input type="checkbox"/> Arm <input type="checkbox"/> Thigh Intranasal
<u>Hyperglycemia (High Blood sugar) Treatment:</u> <input checked="" type="checkbox"/> Provide water and access to bathroom		If Blood Glucose is > 250mg/dl twice in a row: <input checked="" type="checkbox"/> Test urine ketones and call parent/guardian if ketones moderate to large <input checked="" type="checkbox"/> See below for insulin instructions if applicable
IMPORTANT: Student should not be sent home from school with elevated blood glucose UNLESS student is too ill to participate in school activities and/or has moderate ketones and vomiting present.		
<u>When to Check Blood glucose:</u> Blood glucose should always be checked when the individual experiences signs and symptoms of low or high blood glucose, when not feeling well, and/or when they experience behavior concerns or someone notices change in behavior. Before Meals: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snacks <div style="float: right; text-align: right;"> Before Activity/Dismissal from school: <input type="checkbox"/> Gym <input type="checkbox"/> Recess - Blood glucose/sensor glucose should be greater than ____mg/dl <input type="checkbox"/> Walking home <input type="checkbox"/> Riding bus - Blood glucose/sensor glucose should be greater than ____mg/dl **See continuous glucose monitoring (CGM) orders if applicable** </div>		

Continued reverse side

Diabetes Action/Management Plan Continued

Student's Name: _____

Blood Glucose Correction/Insulin Dosage	Insulin Type: <input type="checkbox"/> Apidura/Humalog (Lispro) / Novolog (Aspart) / Admelog / Fiasp Other-Please List: _____
Injection Site: <input type="checkbox"/> Abdomen <input type="checkbox"/> Arm <input type="checkbox"/> Buttock <input type="checkbox"/> Thigh – Injections should be given Subcutaneously and rotated	
Correction Factor: Give <input type="checkbox"/> Prior to breakfast/lunch <input type="checkbox"/> Immediately after breakfast/lunch <input type="checkbox"/> Other	
If Blood Glucose is greater than _____ ADD _____ units.	If Blood Glucose is greater than _____ ADD _____ units.
If Blood Glucose is greater than _____ ADD _____ units.	If Blood Glucose is greater than _____ ADD _____ units.
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If Blood Glucose is greater than _____ ADD _____ units.	If Blood Glucose is greater than _____ ADD _____ units.
<input type="checkbox"/> Parent/Guardian authorized to increase or decrease total dose of insulin by <input type="checkbox"/> 1/2 unit <input type="checkbox"/> 1/2-1 unit <input type="checkbox"/> 1-2 units	
Carbohydrates and Insulin Dosage: <input type="checkbox"/> Breakfast <input type="checkbox"/> Snack <input type="checkbox"/> Lunch <input type="checkbox"/> Other:	
Breakfast:	Insulin to Carbohydrate Ratio _____ unit(s) for every _____ grams of carbohydrate
Lunch:	Insulin to Carbohydrate Ratio _____ unit(s) for every _____ grams of carbohydrate
Snack:	Insulin to Carbohydrate Ratio _____ unit(s) for every _____ grams of carbohydrate
STUDENTS CARE: <input type="checkbox"/> REQUIRES FULL SUPERVISION <input type="checkbox"/> Requires some supervision: Ability level should be determined by Provider and Parent/Guardian unless otherwise indicated here: _____ <input checked="" type="checkbox"/> Student may carry insulin with them <input checked="" type="checkbox"/> Student may carry diabetes monitoring supplies with them <input checked="" type="checkbox"/> Student may carry treatment for hypoglycemia with them	
<input type="checkbox"/> Refer to student's 504 plan for additional information or other specific accommodations.	

Signatures: Represent agreement with the above Information/Action Plan

PROVIDER: (print and sign)	DATE:
AGREEMENT: PARENTS ARE RESPONSIBLE FOR PROVIDING ALL NECESSARY MEDICATION TO THE CLINIC IN A TIMELY MANNER. IF STUDENT SELF CARRIES THE SCHOOL NURSE STILL NEEDS TO MAKE SURE THE INHALER IS LABELED CORRECTLY <ul style="list-style-type: none"> I am requesting permission for my child named above to receive medication in accordance with this action plan. I will assume responsibility for safe delivery of the medication/drug to school. The medication must be brought to school in the container in which it was dispensed by the prescriber or licensed pharmacist. I will notify the school immediately if there is any change in the use of the medication or prescribed treatment. A revised action plan will need to be on file signed by the prescriber. I release and agree to hold the Board of Education, it's officials, and it's employees harmless from all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. 	
PARENT/GUARDIAN:	DATE:

Continued to Page 3 if student is on a Continuous Glucose Monitor (CGM)



Diabetes Medical Management Plan for a Student with Diabetes on Continuous Glucose Monitor (CGM)

School Year: _____ Grade/Class: _____

Student's Name: _____ Date of birth: _____

Address: _____ City: _____ Zip: _____

Physician Name (Printed): _____ Physician Phone: _____

Emergency Contact Information

4. Parent/Guardian: _____ Phone: _____
5. Emergency Contact: _____ Phone: _____
6. Emergency Contact: _____ Phone: _____

What is a CGM?

A continuous Glucose Monitor (CGM) reads a person's glucose level from a sensor in the interstitial fluid (under the skin). It can be programmed to alert (vibrate or alarm) for high and low glucose levels. The Dexcom G5, Dexcom G6 and Freestyle Libre are FDA approved as a replacement to finger sticks for use in making diabetes treatment decisions including dosing. A finger stick blood glucose value is required for calibration or if symptoms don't match sensor glucose reading. **Student should not dose off a CGM value unless both a blood glucose reading, and trending arrow are present.**















CGMs contain three parts:

1. Glucose Sensor: Placed just under the skin by the user. The sensor contains an electrode that detects changes in glucose levels.
2. Transmitter: This connects to the sensor and sends results to the receiver.
3. Receiver: This shows the glucose result and allows operation of the CGM.
 - a. This may be within the pump, on a phone or another electronic device (most typically phones)

Most CGMs have software which allows the user to track trends and communicate data to the parent/guardian and healthcare providers.

Alert Settings: A CGM may alert audibly if interstitial glucose is outside the parameters set by parent(s)/guardian.

Arrows: These are located on the screen and indicate the speed at which the glucose levels are changing.

Dexcom G5 Trend Arrows			Change in Glucose
Receiver	App	Glucose Direction	
		Increasing	Glucose is rapidly rising Increasing >3 mg/dL/min or >90 mg/dL in 30 minutes
		Increasing	Glucose is rising Increasing 2–3 mg/dL/min or 60–90 mg/dL in 30 minutes
		Increasing	Glucose is slowly rising Increasing 1–2 mg/dL/min or 30–60 mg/dL in 30 minutes
		Increasing or Decreasing	Glucose is steady Not increasing/decreasing >1 mg/dL/min
		Decreasing	Glucose is slowly falling Decreasing 1–2 mg/dL/min or 30–60 mg/dL in 30 minutes
		Decreasing	Glucose is falling Decreasing 2–3 mg/dL/min or 60–90 mg/dL in 30 minutes
		Decreasing	Glucose is rapidly falling Decreasing >3 mg/dL/min or >90 mg/dL in 30 minutes
No Arrow	N/A	System cannot calculate the velocity and direction of the glucose change	

USE OF CGM AT SCHOOL

STUDENT SHOULD CHECK THEIR BLOOD GLUCOSE WHEN:

The sensor value is < _____ or > _____, If an arrow and glucose reading are absent, during sensor warm up period or if the device indicates you need to check your blood glucose.

NOTIFY PARENT/ GUARDIAN IF:

If the glucose sensor becomes dislodge, soreness, redness or bleeding is noted at the site or the CGM is malfunctioned.

ADDITIONAL INFORMATION:

Parent/Guardian will ensure calibration of CGM daily per recommendation and the CGM reading can be used for

☐ Pre-activity ☐ Dismissal from school ☐ Pre-meal glucose ☐ Snack Other _____

IF YOUR SCHOOL HAS A METAL DETECTOR OR BODY SCANNER CONTACT MANUFACTURER FOR GUIDANCE

Signatures: Represent agreement with the above Information/Action Plan

PROVIDER: (print and sign)	DATE:
AGREEMENT: PARENTS ARE RESPONSIBLE FOR PROVIDING ALL NECESSARY MEDICATION TO THE CLINIC IN A TIMELY MANNER. IF STUDENT SELF CARRIES THE SCHOOL NURSE STILL NEEDS TO MAKE SURE THE INHALER IS LABELED CORRECTLY <ul style="list-style-type: none"> I am requesting permission for my child named above to receive medication in accordance with this action plan. I will assume responsibility for safe delivery of the medication/drug to school. The medication must be brought to school in the container in which it was dispensed by the prescriber or licensed pharmacist. I will notify the school immediately if there is any change in the use of the medication or prescribed treatment. A revised action plan will need to be on file signed by the prescriber. I release and agree to hold the Board of Education, it's officials, and it's employees harmless from all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization 	
PARENT/GUARDIAN:	DATE: