

Student Name: _____

This Plan expires June 30, 20____

School-based Medical Management Plan for the Student with Diabetes Mellitus

To be completed by Parent/Guardian

Student Name: _____ Birthdate: _____ Grade: _____

Mother/Guardian: _____ Phone: (home) _____ (cell) _____

Father/Guardian: _____ Phone: (home) _____ (cell) _____

Other Emergency Contact: _____ Phone: _____ Relationship: _____

Diabetes Health Care Provider: _____ Phone: _____

To be completed by Diabetes Team

Date of Diabetes Diagnosis: _____ Type 1 Type 2 Other: _____

SECTION I - Routine Management

Glucose Levels:

Monitoring method: Continuous glucose monitor (CGM) Type: _____ **OR** Finger Stick

Preferred location: Classroom Office Where convenient

Glucose check performed by: Student, Independently Student, Supervised **OR** Designated School Personnel

Check prior to: Breakfast Snack Lunch Before PE/Recess Before leaving school

Ensure that glucose level is above 100 before physical activity or boarding the bus Other: _____

Always: Check when symptomatic Perform finger stick if symptoms do not match CGM values

❖ If glucose level is low (< _____ or < _____ with symptoms), see Section III, Low Glucose Level (Hypoglycemia)

❖ If glucose level is high (> _____), see Section IV, High Glucose Level (Hyperglycemia)

Insulin Administration: (Type of Insulin per Medication Administration Authorization Form, see Section II)

Preferred administration location: Classroom Office Where convenient

Pen/Syringe: Dosing per: Card Chart Scale InPen* PUMP* Type: _____ (*All settings pre-programmed by parent)

Breakfast: Prior to Immediately after **Lunch:** Prior to Immediately after **Snack (carb coverage only):** Prior to NA Immediately after

Insulin dosage calculated by: Student, Independently Student, Supervised **OR** Designated School Personnel

Student will determine all carb counts independently **OR** Family will provide carb counts to school staff daily

For foods provided by school nutrition services, school staff will ensure student/family has access to carb counts

Insulin administered by: Student, Independently Student, Supervised **OR** Designated School Personnel

Adjustments to Insulin Dosing:

Based on Michigan law (MCL 380.1178) and best practice, written provider/prescriber instructions are required for all medications administered in the school setting. This includes changes to insulin dosing. Written communication between provider/prescriber and parent/guardian (e.g., emails, clinic visit summary, etc.) may be used to adjust insulin dosing until updated Insulin Dosing Tool is received by the Designated School Personnel.

Parents/Guardians have completed training and are authorized by the provider/prescriber to submit written requests to Designated School Personnel for insulin dosing adjustments to increase or decrease total mealtime insulin dose by: +/- _____ units of insulin.

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SECTION II – Medication Administration Authorization (MAA) Form

This form must be completed fully in order for schools to administer the required medication. The school nurse (RN) will call the prescriber, as allowed by HIPAA, if questions arise about the student's medications and/or related diabetes care.

Prescriber's Authorization:

Student Name: _____ Date of Birth: _____ Grade: _____

1. **Medication Name:** Insulin: Admelog Humalog/Lispro Novolog/Aspart Apidra Fiasp

Dose: Per Accompanying Insulin Dosing Tool

Route: Pen/Syringe (Insulin dosing per: Card Chart Scale)

PUMP Type: _____ (All settings pre-programmed into pump by parent/guardian)

InPen (All settings pre-programmed into app by parent/guardian)

Time: Breakfast: Prior to Immediately after

Lunch: Prior to Immediately after

Snack: Prior to Immediately after

Potential Side Effects: _____

Student may self-carry insulin: Yes No **Student may self-administer insulin:** Yes No

2. **Medication Name:** Glucagon

Route & Dose: Injection, Glucagon/Glucagen/Gvoke PFS: 0.5 mg
 1.0 mg

Auto-Injection, Gvoke HypoPen: 0.5mg/0.1mL

1mg/0.2mL

Nasal, Baqsimi Glucagon Nasal Powder: 3mg

Time: When severe low glucose levels are suspected as indicated by unconsciousness, seizure, or extreme disorientation with inability to safely swallow oral quick-acting glucose.

Potential Side Effects: Nausea, Vomiting, Rebound Hyperglycemia, Other: _____

Student may self-carry Glucagon: Yes No

Please see attached supplemental MAA Form for additional medication orders. Additional training provided by a RN, PA, physician, or Certified Diabetes Care and Education Specialist (CDCES) to Designated School Personnel is required.

Prescriber's Signature: _____ Date: _____

(No stamped signatures, please)

Print Name/Title: _____ NPI#: _____

Address: _____

Phone: _____ FAX: _____

Parent/Guardian Authorization:

I request Designated School Personnel to administer the medications as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medications at school. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Reviewed by RN, PA, Physician, or CDCES providing training to Designated School Personnel:

Signature/Title

Date

SECTION III - Responding to a Low Glucose Level (Hypoglycemia)

Below are common symptoms that may be observed when glucose levels are **low**.
Reminder: These symptoms can change, and some students may not display any symptoms.
 Parents **may** choose to circle their child's most common symptoms.

| Symptoms of a Low Glucose Level (Hypoglycemia) | |
|--|--|
| Shaky Weak Sweaty Rapid heartbeat Dizzy Hungry Headache Lack of coordination Seizure Tiredness Loss of consciousness Pale Confusion Irritability/Personality changes Continuous Glucose Monitor (CGM) alarm/arrows Other: _____ | |
| Actions for Treating Hypoglycemia | |
| Treatment for Mild to Moderate Hypoglycemia | Treatment for Severe Hypoglycemia |
| <p>Notify School Nurse or Designated School Personnel as soon as you observe symptoms. If possible, check glucose level via finger stick.</p> <p>Do NOT send student to office alone!</p> <p>Treat for hypoglycemia if glucose level is: <input type="checkbox"/> less than _____ or less than _____ with symptoms.</p> <p>WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.</p> | <p>Student is:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Unconscious <input checked="" type="checkbox"/> Having a seizure <input checked="" type="checkbox"/> Having difficulty swallowing <p>Follow Emergency Steps</p> <ol style="list-style-type: none"> 1. Administer Glucagon 2. Call 9-1-1 3. Activate MERT (Medical Emergency Response Team) |
| "Rule of 15" | Administer Glucagon |
| <p><input type="checkbox"/> Treat with 15 grams of quick-acting glucose (4 oz. juice or 3-4 glucose tabs)</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> Treat with 30 grams of quick-acting glucose (8 oz. juice or 6-8 glucose tabs) if glucose level is less than _____</p> <p><input type="checkbox"/> Wait 15 minutes. Recheck glucose level.</p> <p><input type="checkbox"/> Repeat quick-acting glucose treatment if glucose level is less than _____ mg/dL.</p> <p><input type="checkbox"/> Contact the student's parents/guardians.</p> <p>Then:</p> <p><input type="checkbox"/> If an hour or more before next meal, give a snack of protein and complex carbohydrates</p> <p><input type="checkbox"/> If mealtime and no difficulty swallowing, monitor and allow student to eat lunch while waiting to recheck glucose level.</p> <p><input type="checkbox"/> Once glucose level is greater than _____ and student has finished eating lunch, give insulin to <u>cover meal carbs only.</u></p> | <p><input checked="" type="checkbox"/> Stay with student, protect from injury, turn on side</p> <p><input checked="" type="checkbox"/> Do not put anything into the student's mouth</p> <p><input type="checkbox"/> Suspend or remove insulin pump (if worn)</p> <p><input checked="" type="checkbox"/> Administer Glucagon Per MAA Form:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Injection, Glucagon/Glucagen/Gvoke PFS: <ul style="list-style-type: none"> <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1.0 mg <input type="checkbox"/> Auto-Injection, Gvoke HypoPen: <ul style="list-style-type: none"> <input type="checkbox"/> 0.5mg/0.1ml <input type="checkbox"/> 1mg/0.2ml <input type="checkbox"/> Nasal, Baqsimi Glucagon Nasal Powder: <ul style="list-style-type: none"> <input type="checkbox"/> 3mg <p><input type="checkbox"/> Implement Medical Emergency Response:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Take AED and any emergency medical supplies to location; <input checked="" type="checkbox"/> Inform Central Administration of emergency; <input checked="" type="checkbox"/> Contact parents; Meet them in the parking lot; <input checked="" type="checkbox"/> Meet the ambulance/direct traffic; <input checked="" type="checkbox"/> Provide copy of student medical record to EMS; <input checked="" type="checkbox"/> Control the scene; <input checked="" type="checkbox"/> Document emergency and response on Emergency Response/Incident Report form; <input checked="" type="checkbox"/> Conduct debriefing session of incident and response following the event. |

SECTION IV - Responding to High Glucose Levels (Hyperglycemia)

Below are common symptoms that may be observed when glucose levels are **high**.
Reminder: These symptoms can change, and some students may not display any symptoms.
 Parents **may** choose to circle their child's most common symptoms.

| Symptoms of a High Glucose Level (Hyperglycemia) | | | | | | |
|--|---------------------|-----------|------------------------------|--------------------|----------------------------|----------|
| Increased thirst | Increased urination | Tiredness | Increased appetite | Decreased appetite | Blurred Vision | Headache |
| Sweet, fruity breath | Dry, itchy skin | Achiness | Stomach pain/nausea/vomiting | Seizure | Loss of consciousness/coma | |
| Continuous Glucose Monitor (CGM) alarm/arrows | | | Other: _____ | | | |

Actions for Treating Hyperglycemia

| Treatment for Hyperglycemia | Treatment for Hyperglycemia Emergency |
|-----------------------------|---------------------------------------|
|-----------------------------|---------------------------------------|

| | |
|--|---|
| Notify School Nurse or Designated School Personnel as soon as you observe symptoms. | Call 9-1-1 Activate Medical Emergency Response |
|--|---|

| | |
|---|--|
| <p><input type="checkbox"/> For glucose level less than 300:</p> <ul style="list-style-type: none"> ✓ If not mealtime – do not give correction dose of insulin, offer water, return to normal routine if feeling well ✓ If mealtime, give insulin as prescribed (See Section I, Routine Management, Insulin Administration) <p><input type="checkbox"/> For glucose level 300 or greater:</p> <ul style="list-style-type: none"> ✓ If mealtime, give insulin as prescribed (See Section I, Routine Management, Insulin Administration) ✓ Have student check ketones <p><input type="checkbox"/> Positive Ketones:</p> <ul style="list-style-type: none"> ✓ Call parent/guardian <ul style="list-style-type: none"> ▪ Trace or Small - attempt to flush, remain in school if feeling well and no vomiting ▪ Moderate or Large - parent pick-up immediately ✓ Give 8-16 oz. of water hourly ✓ No exercise, physical education, or recess ✓ Recheck ketones at next urination ✓ If on pump, check infusion set/pump site: <ul style="list-style-type: none"> ▪ Is tubing disconnected? ▪ Is there wetness around the pump site, etc.? <p><input type="checkbox"/> Negative Ketones:</p> <ul style="list-style-type: none"> ✓ If not mealtime - offer water, return to normal routine if feeling well <p><input type="checkbox"/> If no ketone strips are available:</p> <ul style="list-style-type: none"> ✓ Treat as Positive Ketones ✓ Request strips from family | <p><input type="checkbox"/> Call 9-1-1 if severe symptoms are present. Severe symptoms may include:</p> <ul style="list-style-type: none"> ✓ Abdominal pain ✓ Nausea/Repetitive Vomiting ✓ Change in level of consciousness ✓ Lethargy <p><input type="checkbox"/> Implement Medical Emergency Response:</p> <ul style="list-style-type: none"> ✓ Take AED and any emergency medical supplies to location; ✓ Inform Central Administration of emergency; ✓ Contact parents; Meet them in the parking lot; ✓ Meet the ambulance/direct traffic; ✓ Provide copy of student medical record to EMS; ✓ Control the scene; ✓ Document emergency and response on Emergency Response/Incident Report form; ✓ Conduct debriefing session of incident and response following the event. |
|---|--|

Student Name: _____

This Plan expires June 30, 20____

To be completed by Trainer of Student-specific School Health (SSH) Team in collaboration with all SSH Team members.

SECTION IV – Additional Supports

- Snack daily at: _____ Snack as needed for low glucose level Allow unlimited access to food
- Allow unlimited access to water or bathroom Have 15 grams of quick-acting glucose available at site of physical activity
- For special occasions that involve food: always contact parent for guidance **OR** student can self-manage
- Out of classroom, student will travel with: buddy adult
 - always **OR** when support is requested or is obviously needed
- Fieldtrips - Student will be accompanied by trained school personnel, unless parent volunteers to attend (parent attendance not required)
- Extra-curricular Activities – Parent and student will inform DSP of participation to ensure trained school personnel are present
- Plan for access to food and appropriate support during School Emergencies developed/implemented
- Staff/student plan to completely silence alarms when hiding for safety developed/implemented, and includes practice during drills
- Record all care provided/send documentation home: Weekly When requested by parent Other: _____
- Evaluate for eligibility for a Section 504 Academic Accommodations Plan

Location of Glucagon (Glucagon/Gvoke/Baqsimi): In Office In Classroom With Student Other: _____

Location of Other Diabetes Supplies (see attached list): In Office In Classroom With Student Other: _____

School Name: _____ Principal: _____

School Address: _____

SSH Team consists of:

Parent, Student, Designated School Personnel

AND

RN, Physician, PA, or Certified Diabetes Care and Education Specialist (CDCES)

The following Designated School Personnel have received training to support implementation of this plan:

| | |
|-------------|--------------|
| _____ | _____ |
| Name | Title |
| _____ | _____ |
| Name | Title |
| _____ | _____ |
| Name | Title |
| _____ | _____ |
| Name | Title |
| _____ | _____ |
| Name | Title |

Training provided by:

Signature/Title Date