Mayfield City Schools
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Diabetes Management Plan

Sections 1-4 to be completed by Parent/Guardian Sections 5-12 to be completed by Healthcare Provider

The following section must be completed by the PARENT/GUARDIAN:

School:	Grade:	Year:
Student's Last Name:	First Name:	☐ M ☐ F Date of Birth:

____/____/_____ _____ (_____) _____ (_____) _____
Date Parent/Guardian Signature Home/Cell Phone Emergency Phone

Section 1: **Student Schedule**

Typical Arrival Time: _____ Typical Dismissal Time: _____

Travels to school by:	Meal Times:	Physical Activity:	Travels to:
☐ Foot/Bicycle ☐ Car ☐ Bus ☐ Attends Before School Program *check all that apply	☐ Breakfast _____ ☐ AM Snack _____ ☐ Lunch _____ ☐ PM Snack _____ ☐ Pre-Dismissal Snack _____ *check all that apply	☐ Gym ☐ Recess ☐ Sports ☐ Additional Information: _____ *check all that apply	☐ Home -or- ☐ After School Program ▪ Via: ☐ Foot/Bicycle ☐ Car ☐ Bus *check all that apply

Section 2: **Self-Management Skills** (Parent/Guardian Complete)

Support Required		Full Support*	Supervision*	Self-Care*
Glucose Monitoring	Meter CGM ☐ Requires Calibration	☐ ☐	☐ ☐	☐ ☐
Carbohydrate Counting		☐	☐	☐
Insulin Administration	Syringe Pen Pump	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Can Calculate Insulin Doses ☐ Yes ☐ No If yes, please check box->		☐	☐	☐
Glucose Management	Low Glucose High Glucose	☐ ☐	☐ ☐	☐ ☐

Self-Carry Diabetes Supplies ☐ Yes ☐ No Please specify items: _____
Smart Phone ☐ Yes ☐ No

Device Independence

☐ CGM ☐ Interpretation and Alarm ☐ Sensor Insertion ☐ Calibration	☐ Insulin Pumps ☐ Bolus ☐ Connects/Disconnects ☐ Temp Basal Adjustment	☐ Interpretation and Alarm Management ☐ Site Insertion ☐ Cartridge Change

*Full Support: All care performed by school nurse and trained staff (as permitted by state law).
*Supervision: Trained staff to assist and supervise. Guide and encourage independence.
*Self-Care: Manages diabetes independently. Support is provided upon request and as needed.

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Section 3: **Student Recognition of High or Low Glucose Symptoms** (Parent/Guardian Complete)

High		**Low**	
☐ Thirsty	☐ Abdominal Discomfort	☐ None	☐ Dizzy
☐ Frequent Urination	☐ Nausea/Vomiting	☐ Hungry	☐ Irritable
☐ Fatigued/Tired/Drowsy	☐ Fruity Breath	☐ Shaky	☐ Unable to Concentrate
☐ Headache	☐ Unaware	☐ Pale	☐ Confusion
☐ Blurred Vision	☐ Other:	☐ Sweaty	☐ Personality Changes
☐ Warm/Dry/Flushed Skin	_____	☐ Tired/Sleepy	☐ Other:
		☐ Tearful/Crying	_____

Has the student lost consciousness, experienced a seizure or required Glucagon: ☐ YES ☐ NO
If YES, date of last event: _____

Has the student been admitted for DKA after diagnosis: ☐ YES ☐ NO
If YES, date of last event: _____

Section 4: **Student Monitoring at School** (Parent/Guardian Complete)

Monitor Glucose

- ☐ Before Meals
- ☐ With Physical Complaints/Illness (include Ketone testing)
- ☐ High or Low Glucose Symptoms
- ☐ Before Exams
- ☐ Before Physical Activity
- ☐ After Physical Activity
- ☐ Before Leaving School
- ☐ Other: _____

Continuous Glucose Monitoring (CGM)

Specify Brand and Model: _____

Specify Viewing Equipment: ☐ Device Reader ☐ Smart Phone ☐ Insulin Pump ☐ Smart Watch ☐ iPod/iPad/Tablet

☐ CGM is remotely monitored by parent/guardian. Document individualized communication plan in Section 504 or other plan to minimize interruptions for the student during school hours.

☐ May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

CGM Alarms: ☐ Low Alarm _____mg/dL ☐ High Alarm _____mg/dL if applicable

School Permissions:

- ☐ Permit student access to viewing device at all times.
- ☐ Permit access to School Wi-Fi for sensor data collection and date sharing.
- ☐ Do not discard transmitted if sensor falls.

Perform Finger Stick If:

- ☐ Glucose reading is below _____mg/dL or above _____mg/dL
- ☐ If CGM is still reading below _____mg/dL (DEFAULT 70 mg/dL) for 15 minutes follow low treatment
- ☐ CGM sensor is dislodged or sensor reading is unavailable
- ☐ Sensor readings are inconsistent or in the presence of alerts/alarms
- ☐ Dexcom does not have both a number and arrow present
- ☐ Libre displays Check Blood Glucose Symbol
- ☐ Using Medtronic system with Guardian sensor

Notify Parent/Guardian if glucose is: below _____mg/dL (<55 mg/dL DEFAULT) above _____mg/dL (>300 mg/dL DEFAULT)

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Section 5: **Insulin Doses at School** (Healthcare Provider to Complete)

Insulin Administered Via:

☐ Syringe ☐ i-Port ☐ Insulin Pen- ☐ Whole Units ☐ Half Units ☐ Smart Pen ☐ Other	☐ Insulin Pump (Specify Brand and Model):_____ ☐ Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device ☐ Insulin Pump is using DIY Lopping Technology (child/parent manages device independently, nurse will assist with all other diabetes management)

☐ Dosing to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section labeled "Dosing Table")

Insulin Administration Guidelines

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with students that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when student does not complete their meal.

☐ **Prior to Meal** (DEFAULT)
☐ **After Meal** as soon as possible and within 30 minutes
☐ **Snacking** avoid snacking _____ hours (DEFAULT 2 hours) before and after meals

Partial Dose Prior to Meal: (preferred for unpredictable eating patterns using **insulin pump therapy**)

☐ Calculate meal dose using _____ grams of carbohydrate prior to the meal
☐ Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)
☐ May advance to Prior to Meal when student demonstrates consistent eating patterns

For injections, Calculate Insulin Dose to the Nearest:

☐ Half Unit (round down for <0.25 or <0.75 and round up for ≥ 0.25 or ≥ 0.75)
☐ Whole Unite (round down for <0.5 and round up for ≥ 0.5)

Supplemental Insulin Orders

☐ Check for **KETONES** before administering insulin dose if BG > _____mg/dL (DEFAULT > 300 mg/dL or > 250 mg/dL on insulin pump) or if student complains of physical symptoms. Refer to section labeled "High Glucose Management"
☐ Parents/Guardians are authorized to adjust insulin dose +/- _____ units
  ☐ Insulin dose +/- _____ units
  ☐ Insulin dose +/- _____ %
  ☐ Insulin to Carb Ration +/- _____ grams/units
  ☐ Insulin Factor +/- _____mg/dL/unit

Additional guidance on Parent/Guardian adjustments:

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Section 6: **Dosing Table** (Healthcare Provider to Complete)

Insulin: (administered for food and/or correction)		
Rapid Acting Insulin: ☐ Humalog.Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) ☐ Other _____	**Ultra Rapid Acting Insulin:** ☐ Fiasp (Aspart) ☐ Lyumjev (Lispro-aabc) ☐ Other _____	**Other Insulin:** ☐ Humulin R ☐ Novolin R

Meals and Times	**Food Dose**		**Glucose Correction Dose** ☐ Use Formula ☐ Sliding Scale	**PE/Activity Day Dose**
Select if dosing is required for meal	☐ **Carbohydrate Ratio** Total grams of Carbohydrate divided by Carbohydrate Ratio = Carb Dose	☐ **Fixed Meal Dose**	**Formula: (**Pre-Meal Glucose Reading minus **Target Glucose**) divided by **Correction Factor** = Correction Dose ☐ May give Correction dose every _____ hours as needed (DEFAULT 3 hours)	**Adjust:** ☐ **Carbohydrate Dose** ☐ **Total Dose** Indicate dose instructions below
☐ **Breakfast**	Breakfast Carb Ratio= _____ g/unit	**Breakfast** _____ units	☐ **Target Glucose** is: _____ mg/dL and **Correction Factor** is: _____ mg/dL/unit ☐ **No Correction Dose**	Carb Ratio: _____ g/unit Subtract: _____ % Subtract: _____ units
☐ **AM Snack**	AM Snack Carb Ratio= _____ g/unit	**AM Snack** _____ units	☐ **Target Glucose** is: _____ mg/dL and **Correction Factor** is: _____ mg/dL/unit ☐ **No Correction Dose**	Carb Ratio: _____ g/unit Subtract: _____ % Subtract: _____ units
	☐ No Carb Dose ☐ No Insulin if < _____grams			
☐ **Lunch**	Lunch Carb Ratio= _____ g/unit	**Lunch** _____ units	☐ **Target Glucose** is: _____ mg/dL and **Correction Factor** is: _____ mg/dL/unit ☐ **No Correction Dose**	Carb Ratio: _____ g/unit Subtract: _____ % Subtract: _____ units
☐ **PM Snack**	PM Snack Carb Ratio= _____ g/unit	**PM Snack** _____ units	☐ **Target Glucose** is: _____ mg/dL and **Correction Factor** is: _____ mg/dL/unit ☐ **No Correction Dose**	Carb Ratio: _____ g/unit Subtract: _____ % Subtract: _____ units
	☐ No Carb Dose ☐ No Insulin if < _____grams			
☐ **Dinner**	Dinner Carb Ratio= _____ g/unit	**Dinner** _____ units	☐ **Target Glucose** is: _____ mg/dL and **Correction Factor** is: _____ mg/dL/unit ☐ **No Correction Dose**	Carb Ratio: _____ g/unit Subtract: _____ % Subtract: _____ units

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Section 7: **Correction Sliding Scale** (Healthcare Provider to Complete)

☐ Meals Only	☐ Meals and Snacks	☐ Every ____ Hours as Needed
_____ to _____ mg/dL= _____units	_____ to _____ mg/dL= _____units	_____ to _____ mg/dL= _____units
_____ to _____ mg/dL= _____units	_____ to _____ mg/dL= _____units	_____ to _____ mg/dL= _____units
_____ to _____ mg/dL= _____units	_____ to _____ mg/dL= _____units	_____ to _____ mg/dL= _____units

Section 8: **Long Acting Insulin** (Healthcare Provider to Complete)

_____ Time	☐ Lantus, Basaglar, Toujeo (Glargine) ☐ Levemir (Detemir) ☐ Tresiba (Degludec) ☐ Other _____	_____ Units	☐ Daily Dose ☐ Overnight Field Trip Dose ☐ Disaster/Emergency Dose	Subcutaneously

Section 9: **Other Medications** (Healthcare Provider to Complete)

_____ Time	☐ Metformin ☐ Other_____	_____ Units	☐ Daily Dose ☐ Overnight Field Trip Dose ☐ Disaster/Emergency Dose	Route

Section 10: **Low Glucose Prevention-Hypoglycemia** (Healthcare Provider to Complete)

Allow Early Interventions	☐ Allow Mini-Dosing of carbohydrate (i.e.,1-2 glucose tablets) when low glucose is predicted, sensor readings are dropping (down arrow) at _____ mg/dL (DEFAULT 80 mg/dL or 120 mg/dL prior to exercise) or with symptoms. ☐ Allow Student to carry and consume snacks ☐ School staff to administer ☐ Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (DEFAULT)
Insulin Management (Insulin Pumps)	**Temporary Basal** Rate Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia ☐ Pre-Programmed Temporary Basal Rate Named _____ (Omnipod) ☐ Temp Target (Medtronic) ☐ Exercise Activity Setting (Tandem) ☐ Activity Feature (Omnipod 5) **Start:** _____ minutes prior to exercise for _____ minutes duration (DEFAULT 1 hour prior, during, and 2 hours following exercise-***Please note must be stopped manually after 2 hours, no auto shut off***) **Initiated By:** ☐ Student ☐ Trained School Staff ☐ School Nurse
Exercise Glucose Monitoring	☐ prior to exercise ☐ every 30 minutes during extended exercise ☐ following exercise ☐ with symptoms ***Delay exercise** if glucose is <_____ mg/dL (120 mg/dL DEFAULT)
Pre-Exercise Routine	☐ Fixed Snack: Provide _____ grams of carbohydrate prior to physical activity if glucose < _____ mg/dL ☐ Added Carbs: If glucose is < _____mg/dL (120 DEFAULT) give _____ grams of carbohydrates (15 DEFAULT) ☐ TEMPORARY BASAL RATE as indicated above

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Section 11: **Low Glucose Management-Hypoglycemia** (Healthcare Provider to Complete)

Low Glucose below _____ mg/dL (below 70 mg/dL DEFAULT) or below _____mg/dL before/during exercise (DEFAULT is < 120 mg/dl).

1. If student is awake and able to swallow give _____ grams of fast acting carbohydrate (DEFAULT 15 grams). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.
   - ☐ School nurse/parent may change amount given
2. Check blood glucose every 15 minutes and re-treat until glucose > mg/dL (DEFAULT is 80 mg/dL or 120 mg/dL before exercise).

SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)

- ☐ Administer Glucagon
- ☐ Position student on their side and monitor for vomiting
- ☐ Call 911 and notify parent/guardian.
- ☐ If BG meter is available, confirm hypoglycemia via BG fingerstick.
- ☐ Do not delay treatment if meter is not immediately available.
- ☐ If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site.
- ☐ Keep pump with student.
- ☐ Medications to be Given:
  - ☐ Glucagon Emergency Kit by IM injection
    - ☐ 0.5 mg or ☐ 1.0 mg
  - ☐ Gvoke by SC injection
  - ☐ Auto-Injection Gvoke HypoPen Dose: 0.5 mg or 1.0 mg
  - ☐ Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector
  - ☐ Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe
  - ☐ Baqsimi Nasal Glucagon 3 mg

Section 12: **High Glucose Management-Hyperglycemia** (Healthcare Provider to Complete)

Management of High Glucose over _____ mg/dL (Default is 300 mg/dL OR 250 mg/dl if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 30 minutes. May consume fluids in classroom. Allow frequent bathroom privileges.
2. **Check for Ketones** (before giving insulin correction)

a. **If Trace or Small Urine Ketones** (0.1 – 0.5 mmol/L if measured in blood)

- Consider insulin correction dose. Refer to the “Correction Dose” Section for designated times correction insulin may be given.
- Can return to class and PE unless symptomatic
- Recheck glucose and ketones in 2 hours

b. **If Moderate or Large Urine Ketones** (0.6 – 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.

- Contact parents/guardian or, if unavailable, healthcare provider
- **Administer correction dose via injection**. If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the “Blood Glucose Correction Dose” Section
- If using insulin pump change infusion site/cartridge or use injections until dismissal.
- No physical activity until ketones have cleared
- Report nausea, vomiting, and abdominal pain to parent/guardian to take student home.
- Call 911 if changes in mental status and labored breathing are present and notify parents/guardians

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Signature

(Licensed Prescriber's Stamp)	Licensed Prescriber's Printed Name: _____ Licensed Prescriber's Signature: _____ Date: _____/_____/_____ Telephone Number: (_____) _____
Reviewed by School Nurse or Designee: First Name: Last Name:	Signature:

Rev 5/22

***Please note a new form is required every school year

A Medication Administration Form Must Be Completed for Each Medication That is Listed on This Plan

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