

**Children's Physician Group**  
**DIABETES MEDICAL MANAGEMENT PLAN**  
School Year: \_\_\_\_\_

Scholar's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone at Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell/Pager: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone at Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell/Pager: \_\_\_\_\_

Other emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

**BLOOD GLUCOSE (BG) MONITORING:**

- Before meals
- as needed for suspected low/high BG
- 2 hours after correction
- Midmorning
- Mid-afternoon
- Before dismissal
- May use Continuous Glucose Monitor (CGM) in place of finger stick blood sugar monitoring.

**INSULIN ADMINISTRATION:**

**Insulin delivery system:**  Syringe or  Pen or  Pump    **Insulin type:**  Humalog or  Novolog or  Apidra or  Admelog  Fiasp

**MEAL INSULIN:** (Best if given right **before eating**. For small children, can give within 15-30 minutes of the first bite of food-or right after meal)

- Insulin to Carbohydrate Ratio:  
Breakfast: 1 unit per \_\_\_\_\_ grams carbohydrate  
Lunch: 1 unit per \_\_\_\_\_ grams carbohydrate
- Fixed Dose per meal:  
Breakfast: Give \_\_\_\_\_ units/Eat \_\_\_\_\_ grams of carbohydrate  
Lunch: Give \_\_\_\_\_ units/Eat \_\_\_\_\_ grams of carbohydrate

**CORRECTION INSULIN:** (For high blood sugar. Add before **MEAL INSULIN** to **CORRECTION INSULIN** for **TOTAL INSULIN** dose.)

- Use the following correction formula  
For pre-meal blood sugar over \_\_\_\_\_  
  
(BG - \_\_\_\_\_) ÷ \_\_\_\_\_ = extra units insulin to provide
- Sliding Scale:  
BG from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units  
BG from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units  
BG from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units  
BG from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units  
> \_\_\_\_\_ = \_\_\_\_\_ units

**SNACK:**  A snack will be provided each day at: \_\_\_\_\_  
**Carbohydrate coverage only for snack (No BG check required):**  
 No coverage for snack  
 1 unit per \_\_\_\_\_ grams of carb  
 Fixed snack dose: Give \_\_\_\_\_ units/Eat \_\_\_\_\_ grams of carb

**PARENTAL AUTHORIZATION to Adjust Insulin Dose:**

- YES  NO Parents/guardians are authorized to increase or decrease insulin-to-carb ratio within the following range:  
1 unit per prescribed grams of carbohydrate, +/- \_\_\_\_\_ grams of carbohydrate
- YES  NO Parents/guardians are authorized to increase or decrease correction dose with the following range: +/- \_\_\_\_\_ units of insulin
- YES  NO Parents/guardians are authorized to increase or decrease fixed insulin dose with the following range: +/- \_\_\_\_\_ units of insulin

**MANAGEMENT OF LOW BLOOD GLUCOSE:**

|  |  |
|--|--|
| <p><b>MILD low sugar: Alert and cooperative student (BG below _____)</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Never leave student alone</li><li><input type="checkbox"/> Give 15 grams glucose; recheck in 15 minutes</li><li><input type="checkbox"/> If BG remains below 70, retreat and recheck in 15 minutes</li><li><input type="checkbox"/> Notify parent if not resolved</li><li><input type="checkbox"/> If no meal is scheduled in the next hour, provide an additional snack with carbohydrate, fat, protein.</li><li><input type="checkbox"/> If CGM alarms/reads under LOW LIMIT after 15 minutes of treating a low, student should verify BG with finger stick.</li></ul> | <p><b>SEVERE low sugar: Loss of consciousness or seizure</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Call 911. Open airway. Turn to side.</li><li><input type="checkbox"/> Glucagon injection IM/SubQ <input type="checkbox"/> _____ <input checked="" type="checkbox"/> 0.50mg</li><li><input type="checkbox"/> Notify parent.</li><li><input type="checkbox"/> For students using insulin pump, stop pump by placing in "suspend" or stop mode, disconnecting at pigtail or clip, and/or removing an attached pump. If pump was removed, send with EMS to hospital.</li></ul> |
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**MANAGEMENT OF HIGH BLOOD GLUCOSE: (above \_\_\_\_\_ mg/dl)**

- Sugar-free fluids/frequent bathroom privileges.
- If BG is greater than 300 and it's been 2 hours since last dose, give  HALF  FULL correction formula noted above.
- If BG is greater than 300 and it's been 4 hours since last dose, give **FULL** correction formula noted above.
- If BG is greater than \_\_\_\_\_, check for ketones. Notify parent if ketones are present.
- Child should be allowed to stay in school unless vomiting with moderate or large ketones present.
- If the CGM alarms/reads over HIGH LIMIT, student may give correction bolus according to above instructions

**MANAGEMENT DURING PHYSICAL ACTIVITY:**

Scholar shall have easy access to fast-acting carbohydrates, snacks, and blood glucose monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below \_\_\_\_\_ mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

- Check blood sugar right before physical education to determine need for additional snack.
- If BG is less than \_\_\_\_\_ mg/dl, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.
- Student may disconnect insulin pump for 1 hour or decrease basal rate by \_\_\_\_\_.
- For new activities: Check blood sugar before and after exercise only until a pattern for management is established.
- A snack is required prior to participation in physical education.

Scholar's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**NOTIFY PARENT of the following conditions: (If unable to reach parent, call diabetes provider office at \_\_\_\_\_)**

- a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon.
- b. Blood sugars in excess of 300 mg/dl, when ketones present.
- c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

**SPECIAL MANAGEMENT OF INSULIN PUMP:**

- Contact Parent in event of:
  - Pump alarms or malfunctions
  - Detachment of dressing / infusion set out of place
  - Leakage of insulin
  - Student must give insulin injection
  - Student has to change site
  - Soreness or redness at site
  - Corrective measures do not return blood glucose to target range within \_\_\_\_\_ hrs.
- Parents will provide extra supplies including infusion sets, reservoirs, batteries, pump insulin, and syringes.

**SPECIAL MANAGEMENT CONTINUOUS GLUCOSE MONITORS (CGM): \_\_\_\_\_ (Brand of CGM)**

- Contact Parent in event of: issue with alarms or malfunctions

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| <p><b>This scholar requires assistance by a School Nurse or Trained Diabetes Personnel with the following aspects of diabetes management:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Monitor and record blood glucose levels (as instructed on page</li> <li><input checked="" type="checkbox"/> Respond to elevated or low blood glucose levels</li> <li><input type="checkbox"/> Administer glucagon when required</li> <li><input type="checkbox"/> Calculate and give insulin Injections</li> <li><input type="checkbox"/> Administer oral medication</li> <li><input type="checkbox"/> Monitor blood or urine ketones</li> <li><input type="checkbox"/> Follow instructions regarding meals and snacks</li> <li><input type="checkbox"/> Follow instructions as related to physical activity</li> <li><input type="checkbox"/> Respond to CGM alarms. Check BG with glucose meter if symptoms do NOT match sensor readings. Treat using Management Plan on page 1.</li> <li><input type="checkbox"/> Insulin pump management administer insulin, inspect infusion site, contact parent for problems</li> <li><input type="checkbox"/> Provide other specified assistance:</li> </ul> <hr style="width: 100%;"/> | <p><b>This student may independently perform the following aspects of diabetes management:</b></p> <p>Monitor blood glucose:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> in the classroom</li> <li><input type="checkbox"/> in the designated clinic office</li> <li><input type="checkbox"/> in any area of school and at any school related event</li> </ul> <ul style="list-style-type: none"> <li><input type="checkbox"/> Monitor urine or blood ketones</li> <li><input type="checkbox"/> Calculate and give own injections</li> <li><input type="checkbox"/> Calculate and give own injections with supervision</li> <li><input type="checkbox"/> Treat hypoglycemia (low blood sugar)</li> <li><input type="checkbox"/> Treat hyperglycemia (elevated blood sugar)</li> <li><input type="checkbox"/> Carry supplies for blood glucose monitoring</li> <li><input type="checkbox"/> Carry supplies for insulin administration</li> <li><input type="checkbox"/> Carry prescription medication listed in the school DMMP</li> <li><input type="checkbox"/> Determine own snack/meal content</li> <li><input type="checkbox"/> Manage insulin pump</li> <li><input type="checkbox"/> Replace insulin pump infusion set</li> <li><input type="checkbox"/> Management of CGM (Calibrating, monitoring, and responding to alarms)</li> <li><input type="checkbox"/> Cell phone is used as CGM receiver</li> </ul> |
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**LOCATION OF SUPPLIES/EQUIPMENT:** (Parent will provide and restock all supplies, snacks and low blood sugar treatment supplies.) This section will be completed by school personnel and parent:

|                                 | Clinic room              | With student             |                                 | Clinic room              | With student             |
|---------------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|
| Blood glucose equipment         | <input type="checkbox"/> | <input type="checkbox"/> | Glucagon kit                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin administration supplies | <input type="checkbox"/> | <input type="checkbox"/> | Glucose gel                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Ketone supplies                 | <input type="checkbox"/> | <input type="checkbox"/> | Juice /low blood glucose snacks | <input type="checkbox"/> | <input type="checkbox"/> |

*My signature provides authorization for the above Diabetes Mellitus Medical Management Plan. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.*

**SIGNATURE of AUTHORIZED PRESCRIBER:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
 Authorized Prescriber: MD, NP, PA

**Name of Authorized Prescriber:**

**Address:**

**Phone:**

**SIGNATURES**

I, (Parent/Guardian) \_\_\_\_\_ understand that all treatments and procedures may be performed by the student and/or Trained Diabetes Personnel within the school, or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by Georgia state law.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

CLINIC ASSISTANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_