Carman-Ainsworth Community Schools

Diabetes Medical Management Plan

Office Use Only
☐ Uploaded to Synergy Health Doc
☐ Synergy (Notifications, Health)
☐ Notify RN, copy sent via pony
Initials/Date_____

Student	**Date of Birth**	☐**Type I** ☐**Type II**
School:	Year: _____ - _____	Parent/Guardian Cell Phone Alt Phone
Teacher/1st Hour		
Grade:	**Valid for Current School Year Only**	

Insulin/Medication Supervision: ☐ Needs supervision with insulin ☐ Student can perform without supervision ☐ Requires staff to perform

Blood Glucose Monitoring: ☐ Needs supervision to test glucose ☐ Student can perform without supervision ☐ Requires staff to perform

Times to Check Glucose: ☐ Before lunch ☒ Signs/symptoms of hypo/hyperglycemia ☐ Other_____

Supplies (provided by parent/guardian): All supplies to be kept in office with exception of continuous glucose monitors and insulin pumps. Snacks may be kept in lockers/classrooms as allowed by building policy.

Alcohol swab use (as provided by parent/guardian) for testing/injections: ☐specify if not allowed, or other method preferred_____

☒ Check Ketones when above 300 or as specified_____ (Ketone strips provided by parent/guardian)

**If ketones are positive, student will be sent home **If ketone strips are not available, student will be assumed positive and sent home

Target Blood Glucose: ☐ _____

Insulin/Glucose

☐Humalog
☐Novolog
☐Other_____

Emergency Glucose

☐Tablets
☐Glucagon
☐Other_____

*Authorization to Administer Medication Form Required for Each Medication Above

Sliding Scale Coverage

☐See attached scale
_____ give __ units
_____ give __ units
_____ give __ units
_____ give __ units
_____ give __ units

Carbohydrate Counting

☐No carb counting
☐See attached scale

Insulin Pump (Calculations done by pump)

Type of Pump_____
Insulin/Carb Ratio_____
Correction Factor _____
Student Self Sufficient Yes____ No____

Continuous Glucose Monitoring CGM

☐Yes ☐No
Type _____
Student Self Sufficient Yes____ No____
*Check with glucose meter if symptoms do not match CGM readout, if malfunction, or per parent/student request.

PE/Recess

☐ Check before PE/Recess
Exclude from PE/Recess if glucose is below_____ or above_____
☐ May return to activity when glucose returns back to desired range

☐ Snack required before activity
☐ Snack required after activity
☐ Other restrictions/considerations_____
_____
_____

Must have an Authorization to Administer Medication form for **EACH** medication. New forms must be submitted for any changes.

Updated/Reviewed 12/21 SK

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*If student's blood sugar is not in range or student is symptomatic, check glucose and follow steps below.

*Do not send student to office alone if unwell, provide escort.

*If any intervention below is initiated, parent should be contacted, even if student remains in school.

*If unsure/unable to check blood sugar, treat for low blood sugar until glucometer becomes available.

LOW BLOOD SUGAR

Signs: shaky, nervous, sweaty, pale, confusion, dizzy, irritable, other _____

If student is alert and able to swallow:
Do this: Check glucose
- Give snack (15 gm carb) or tabs (if ordered)
- Wait 15 minutes
- Check glucose
- Continue 15gm carb, 15 min check until glucose is above _____
- Student may go to lunch once goal is reached

If more than an hour before meal, give protein & complex carb snack after goal is reached
Other considerations _____
_____

If student is **UNCONSCIOUS, CANNOT SWALLOW**, having a **SEIZURE**:
Do this: Administer Glucagon/Gvoke/Baqsimi other **emergency medication** provided
Call 9-1-1, activate MERT

HIGH BLOOD SUGAR

Signs: stomachache, thirsty, irritable, confused, frequent bathroom requests other _____

Do This: Check glucose

If less than 300 or _____
Give insulin per orders (if mealtime)
Offer water and allow normal routine (if not mealtime and student feels well)

If above 300 or _____
Give insulin per orders (if mealtime)
Check ketones
Positive: Send home
Give water, no exercise
Negative: Offer water, normal routine (if student feels well)

If above 500 or _____
Student to be sent home regardless of ketone results, request parent/guardian contact physician for further management.

Provider Signature _____ Date _____

Provider Printed Name _____

I give permission to the trained diabetes personnel of Carman-Ainsworth schools to perform and carry out the diabetes care tasks as outlined in the Diabetes Medical Management Plan above. I also consent to the release of the information contained in the plan to all school staff members and other adults who have responsibility for my child and may need to know this information to maintain my child's health and safety. I also give permission to the trained staff to contact my child's physician above regarding this plan and medications.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name_____

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School: ❍**High School** 591-3240/591-3215 (Fax) ❍**Dillon Elem** 591-3590/591-3835 (Fax)
❍**Middle School/Atlantis** 591-3500/591-3594 (Fax) ❍**Dye Elem** 591-3229/591-3310 (Fax)
❍**Randels Elem** 591-3250/591-3225 (Fax) ❍**Rankin Elem** 591-4605/591-8440 (Fax)

Student's Name_____ **DOB** _____/_____/_____

Teacher/First Hour_____ **Grade**_____ **School Year:** _____

To be completed by **Physician**

Name of Medication: INSULIN:_____

Order: (frequency/time) _____ **Dose/Concentration:** _____

Route of Medication: ❍Tablet/Capsule ❍Liquid ❍Inhaler ❍Injection ❍Nebulizer ❍Other _____

Reason for Medication: (optional) _____

Possible side effects: ❍None Anticipated ❍Yes, explain _____

Special storage: ❍None ❍Refrigerate ❍Other_____

Start Date: ❍Once both medicine and completed form are received ❍Other date_____

Stop date: ❍End of school year ❍Other date_____

Self-Administration (Emergency medications)

This student is capable and responsible for carrying and self-administration of this medication:

❍Yes ❍No ❍Yes, with supervision (may self-administer, medication to remain with staff)

Physician Signature_____ **Date**_____

No Stamped Signature

Physician Name_____ **Phone**_____

To be completed by **Parent/Guardian**

I request that (student's name)_____ receive the above medication according to school policy. I give permission for exchange of verbal and written communication between the physician and the school nurse and/or designated school staff regarding my child's medication. I request that my child be assisted in taking the medication described above or be permitted to carry and self-administer as authorized by the physician above. I agree to notify the school in writing if the medication, dosage, schedule, or procedure is changed or eliminated. I will assume responsibility for the safe delivery of the medication to school. I release and agree to hold the Board of Education, its officials, and its employees harmless from and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

*Medication will be destroyed one week after parent notified to pick up or at the end of each school year.

Parent/Guardian Signature_____ Date_____

Parent/Guardian Name_____ Phone_____

*One Authorization to Administer Medication form must be filled out for **EACH** medication the student may take at school

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Student's Name_____ **DOB** _____/_____/_____

Teacher/First Hour_____ **Grade**_____ **School Year:** _____

To be completed by **Physician**

Name of Medication: Emergency Glucose:_____

Order: (frequency/time) _____ **Dose/Concentration:** _____

Route of Medication: ❍Tablet/Capsule ❍Liquid ❍Inhaler ❍Injection ❍Nebulizer ❍Other _____

Reason for Medication: (optional) _____

Possible side effects: ❍None Anticipated ❍Yes, explain _____

Special storage: ❍None ❍Refrigerate ❍Other_____

Start Date: ❍Once both medicine and completed form are received ❍Other date_____

Stop date: ❍End of school year ❍Other date_____

Self-Administration (Emergency medications)

This student is capable and responsible for carrying and self-administration of this medication:

❍Yes ❍No ❍Yes, with supervision (may self-administer, medication to remain with staff)

Physician Signature_____ **Date**_____

No Stamped Signature

Physician Name_____ **Phone**_____

To be completed by **Parent/Guardian**

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Student's Name_____ **DOB** _____/_____/_____

Teacher/First Hour_____ **Grade**_____ **School Year:** _____

To be completed by **Physician**

Name of Medication: Glucose Tabs:_____

Order: (frequency/time) _____ **Dose/Concentration:** _____

Route of Medication: ❍Tablet/Capsule ❍Liquid ❍Inhaler ❍Injection ❍Nebulizer ❍Other _____

Reason for Medication: (optional) _____

Possible side effects: ❍None Anticipated ❍Yes, explain _____

Special storage: ❍None ❍Refrigerate ❍Other_____

Start Date: ❍Once both medicine and completed form are received ❍Other date_____

Stop date: ❍End of school year ❍Other date_____

Self-Administration (Emergency medications)

This student is capable and responsible for carrying and self-administration of this medication:

❍Yes ❍No ❍Yes, with supervision (may self-administer, medication to remain with staff)

Physician Signature_____ **Date**_____

No Stamped Signature

Physician Name_____ **Phone**_____

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