Diabetes Management Plan and School Treatment Authorizations (DMP)

Name: _____ DOB: _____/_____/_____

DMP: Start Date: _____/_____/_____ End Date: _____/_____/_____

This plan outlines the diabetes management for children and adolescents to be used at home or in any community or school setting. This plan is *in accordance with CT State Law and the Regulations of Connecticut State Agencies Section 10-212a-1 through 10-212a-10 Administration of Medications by School Personnel and Administration of Medication During Before- and After-School Programs and School Readiness Programs.*

Part 1: To be completed by diabetes provider (with parent/guardian input where appropriate):

Diabetes Center: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Other health conditions: _____

Diabetes Medication at home: _____ ☐ Has Medical Alert Bracelet

Self-care skills

BG= Blood Glucose

	N/A	Independent	May require some help or supervision	Requires direct assistance by nurse or trained staff
BG monitoring: times, technique, and communication	☐	☐	☐	☐
Knows meaning of BG results and what to do	☐	☐	☐	☐
Draw up or set pen for correct insulin dose:				
• For amount for carbohydrates consumed	☐	☐	☐	☐
• Based on sliding scale	☐	☐	☐	☐
Insulin injection technique	☐	☐	☐	☐
Count carbohydrates	☐	☐	☐	☐
Pump Specific				
Calculate and administer correction bolus	☐	☐	☐	☐
Calculate and set temporary basal rate	☐	☐	☐	☐
Troubleshoot alarms and malfunctions	☐	☐	☐	☐
Disconnect pump	☐	☐	☐	☐
Reconnect pump to infusion set	☐	☐	☐	☐
Change batteries	☐	☐	☐	■
Prepare reservoir and tubing	☐	☐	☐	■
Calculate and set basal profiles/rates	☐	☐	☐	■
Insert tubing set	☐	☐	☐	■
Change site	☐	☐	☐	■

These skills require some degree of student competence &/or family responsibility

Blood Glucose Monitoring

Student's BG goal : _____ to _____ Mg/dl

Check BG at times checked below AND for signs & symptoms of Hyper or Hypo Glycemia

Continuous glucose monitor (CGM)/sensor may be used in place of fingerstick BG

☐ Before meals
☐ Before snacks
☐ Mid-morning
☐ Before P.E. or Recess
☐ After P.E. or Recess
☐ Before Dismissal
☐ Before standardized or major exam
☐ Other

- Clean hands or site as needed
- Use only fingers if low blood sugar suspected
- No alcohol for skin preparation
- Change lancet at least daily

When to call for help: Call parent/guardian and/or diabetes provider if needed:

- Persistent BG < 70 despite prescribed treatment
- Suspected pump or insertion site failure
- 2 consecutive BG > 250, 2 hrs apart &/or moderate to large ketones
- Daily episodes of BG below 70 or above 250 at the same time of day for 3 consecutive school days
- Questions or concerns

Part 2: Insulin Therapy: To be completed by MD /DO/APRN/PA

PUMP: Settings stored in pump, follow pump model procedures Type/Model:

Insulin Type: ☐ **Humalog/Novolog/Apidra** ☐ Other

Management Options for Students who use Continuous Subcutaneous Insulin Infusion (CSII)

☐ Meal bolus and correction for ☐ Lunch and Snacks ☐ Lunch only ☐ Dinner (field trips or after hours)
☐ Meal bolus only for snacks
☐ Correction dose PRN for BG > _____ Mg/dL (Do not give within 2-3 hours of another bolus)
☐ Other:

Planned /Sports Activities: ☐ May disconnect from pump during activity < 1hr ☐ Suspend pump during activity (< 1hr)
Set temporary basal rate at: _____ or ☐ per student if independent ☐ No adjustment necessary

➢ ***DO NOT OVERRIDE PUMP WITHOUT AUTHORIZATION*** (protects against overcorrection and hypoglycemia)

Assess Pump or Site Failure: For 2 consecutive BG > 250, 2 hours apart &/or moderate to large ketones

➢ Back-up insulin by syringe or pen must be kept in school to use if pump or site failure occurs:

- For site failure only, use pump to determine insulin doses
- For pump failure, administer Insulin injection by ☐ Sliding Scale OR ☐ Correction Factor ***As stated below***
  - Before meals and/or every _____ hours

INJECTIONS Insulin ☐ Humalog /Novolog /Apidra ☐ Other ☐ Syringe / Insulin Pen

Type: _____

Management Options for Students who use Multiple Dose Insulin Injections (select those that apply)

☐ Fixed insulin dose at home (amount/times): _____
☐ Fixed insulin dose required at school (amount/times): _____
☐ Carbohydrate goals for snacks/meals: see below.
☐ Sliding scale for meals: *carbohydrate counting if indicated below.*
☐ Carbohydrate Coverage using insulin:carb ratio with ☐ Sliding Scale OR ☐ Correction Factor (see formula below)

Carbohydrate Goals : *may be adjusted by parent/guardian*

Breakfast:	AM Snack:	Lunch:	PM Snack:	Dinner:
Physical Ed/recess	Field trip /After hours:		Other:	

OR

Carbohydrate Coverage (insulin:carb ratio), ***Use for Pump Failure*** ☐ Before Meals ☐ Before Snacks
Do not use sliding scale with snacks

Insulin: Carb Ratio Formula 1 unit of insulin per: ☐ grams of carbohydrates

AND

☐ **Sliding Scale:** *may be used with or without carb coverage*

BG Range (mg/dL)		Give SC insulin
_____	≤ _____	_____ units
_____	to _____	_____ units
_____	to _____	_____ units
_____	to _____	_____ units
_____	to _____	_____ units
_____	to _____	_____ units
_____	to _____	_____ units
_____	to _____	_____ units

OR

☐ **Calculate Correction (insulin sensitivity) Factor**
Target BG: _____ **Correction Factor:** _____

$$\frac{\text{Current BG} - \text{Target BG}}{\text{Correction Factor}} = \text{Units of insulin}$$

Coverage Guidelines for All Meals:

- If BG remains <70, follow hypoglycemia protocol
- If BG > 70 cover with insulin and send to meal
- If BG remains < 70 may send to meal and cover with insulin after student eats

Part 3: Hypoglycemia Management (BG < 70mg/dL)

Usual symptoms include (check all that apply): ☐ dizziness ☐ confusion ☐ sweating ☐ shaky ☐ hunger ☐ fatigue ☐ other: _____

- Location and nurse involvement for hypoglycemia treatment is based on severity of episode, student's self-management skills &/or IHCP, standard management options include:
  - Give 8-16 gms of fast-acting carbohydrate (4oz juice, 3-4 glucose tabs, etc.)
    - Give 1 tube of glucose gel (15gms) between cheek and gum if symptoms require urgent effect
  - Re-test BG in 20 minutes (wait 30 minutes if using pump) to confirm level > 70mg/dL, if not repeat with rapid-acting carbs or lunch/meal (see meal coverage guidelines)
    - *Repeat BG may not be indicated for students who can verbalize improvement of symptoms or for those on a sensor that shows an upward trend in glucose levels*

Administer glucagon : ☐ 0.5mg IM/SC **or** ☐ **1 mg IM/SC in thigh or deltoid, can inject through clothes: PRN for severs and symptomatic hypoglycemia, including in ability to swallow, seizure activity, or unconsciousness; and call 911**

- *Parent guardian responsible for providing glucagon to school if ordered*
- *Glucagon is to be administered by school nurse or qualified school personnel*
- *Field Trip management (including glucagon option) to be assessed by school nurse in collaboration with parent/guardian and diabetes provider (as needed) on an individual basis and in consideration of EMS response times*

Hyperglycemia (BG > 250mg/dL) & Ketones management

- Check urine for ketones if 2 consecutive BG > 250mg/dL &/or has nausea or vomiting
  - If ketones negative, trace, or small and feels well, continue plan and return to class or gym
  - If ketones are moderate or large &/or 2 consecutive BG >250mg/dL:
    - call parent/guardian, if not available, call diabetes provider for insulin dose
    - Follow pump protocol to assess for pump or site failure
    - Hold P.E. or recess until ketones resolved
- Encourage drinking sugar -free (0 carbohydrate) beverage, preferably water, 8 oz every 30-60 minutes
- Do not withhold food

☐ Other:

Prescriber's Signature: _____

Date: _____

Printed or stamped, include phone and fax:

Parent/Guardian Authorization: I hereby request that the above ordered medication and diabetes management procedures be administered by school personnel. I also give my consent for the exchange of information between the prescribing health care provider and school nurse, as needed for the safe implementation of this plan in school.

- ***Parent/Guardian responsible for providing all diabetes medical supplies and snacks/juice to school***
- **School Delay:** Parent/Guardian must notify the school nurse/responsible staff of any change in schedule or insulin

Parent/Guardian Signature: _____ **Date:** _____
Parent/Guardian Signature: **Date:**
Parent/Guardian Signature: **Date:**
Parent/Guardian Signature: **Date:**

School Nurse use Only ☐ **See attached IHCP**

Addendum A: Diabetes Management Plan and School Treatment Authorizations: for changes that persist greater than 5 school days and require medical provider authorization OR for extended field trip

Management Options for Students who use Continuous Subcutaneous Insulin Infusion (CSII)

☐ Meal bolus and correction for ☐ Lunch and Snacks ☐ Lunch only ☐ Dinner (field trips or after hours)
☐ Meal bolus only for snacks
☐ Correction dose PRN for BG > _____ Mg/dL (Do not give within 2-3 hours of another bolus
☐ Other:

Planned /Sports Activities: ☐ May disconnect from pump during activity < 1hr ☐ Suspend pump during activity (< 1hr)
Set temporary basal rate at : _____ or ☐ per student if independent ☐ No adjustment necessary

- **DO NOT OVERRIDE PUMP WITHOUT AUTHORIZATION (Protects against overcorrection and hypoglycemia)**

Assess Pump or Site Failure: For 2 consecutive BG > 250, 2 hours apart &/or moderate to large ketones

- Back-up insulin by syringe or pen must be kept in school to use if pump or site failure occurs:
  - For site failure only, use pump to determine insulin doses
  - For pump failure, administer Insulin injection by ☐ Sliding Scale OR ☐ Correction Factor ***As stated below***
    - Before meals and/or every _____ hours

INJECTIONS	**Insulin Type:**	☐	Humalog	☐ Novolog	☐ Apidra	☐ Other:	
	Delivery Device:	☐	Syringe	☐ Insulin Pen			

Management Options for Students who use Multiple Dose Insulin Injections (select those that apply)

☐ Fixed insulin dose at home amount/times): _____
☐ Fixed insulin dose required at school amount/times): _____
☐ Carbohydrate goals for snacks/meals: see below
☐ Sliding scale for meals, carbohydrate counting if indicated below
☐ Carbohydrate Coverage using insulin:carb ratio with ☐ Sliding Scale OR ☐ Correction Factor (see formula below)

Carbohydrate Goals : *may be adjusted by parent/guardian*

Breakfast:	AM Snack:	Lunch:	PM Snack:	Dinner:
Physical Ed/recess	Field trip /After hours:		Other:	

OR

Carbohydrate Coverage (insulin:carb ratio), ***Use for Pump Failure*** ☐ Before Meals ☐ Before Snacks ***Do not use sliding scale with snacks***

Insulin: Carb Ratio Formula 1 unit of insulin per: ☐ grams of carbohydrates

AND

☐ **Sliding Scale**: *may be used with or without carb coverage*

BG Range (mg/dL)	Give SC insulin
_____ ≤ _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units

OR

☐ **Calculate Correction (insulin sensitivity) Factor**
Target BG: _____ **Correction Factor:** _____

Current BG – Target BG / Correction Factor = ___ Units

Coverage Guidelines for All Meals:

- If BG remains <70, follow hypoglycemia protocol
- If BG > 70 cover with insulin and send to meal
- If BG remains < 70 may send to meal and cover with ir after student eats

Parent/Guardian Signature: _____ **Date:** _____
Parent/Guardian Signature: _____ **Date:** _____
Parent/Guardian Signature: _____ **Date:** _____
Parent/Guardian Signature: _____ **Date:** _____

Addendum B: Diabetes Management Plan (DMP)

Student's Name: _____ DOB ____/____/____

Role of Parents/Guardians in Adjustment of Diabetes Management Plan

It is my professional judgment that the parents/guardians listed below of _____ have sufficient training and experience in adjusting insulin doses and/or revising the diabetes management plan of their child, and therefore may be consulted regarding the insulin dose adjustments administered by a nurse during school time hours and at school-sponsored events, to the extent reasonably practical, understanding that the ***nurse retains his/her professional judgment*** regarding the adjustment dose he/she will administer. One or more of the following are a necessary part of diabetes care for their child in school.

Please refer to the full DMP for the diabetes medical orders and for treatment specifics. Check "yes" to all that apply.

_Yes _No	*Parents/guardians, as named below, may be contacted for consultation before administering a correction dose.
_Yes _No	Parents/guardians, as named below, are authorized to propose an increase or decrease in the correction factor within the following range: *(select one)* • +/-_____units; **OR** • +/-_____% of the prescribed dose according *to* written orders.
_Yes _No	Parents/guardians, as named below, are authorized to propose an increase or decrease in the insulin-to-carbohydrate ratio within the following range: *(select one)* • 1 unit per prescribed +/- _____ grams of carbohydrate; **OR** • +/- ____% of the prescribed dose according to written orders.
_Yes _No	Parents/guardians, as named below, are authorized *to* propose an increase or decrease in the fixed insulin dose within the following range: *(select one)* • +/- _____units of insulin; **OR** • +/- _____% of the prescribed dose according *to* written orders.
_Yes _No	Parents/guardians, as named below, are authorized to propose an increase or decrease in the consumption of carbohydrates at any time within the carbohydrate goals specified in the DMP.
_Yes _No	For children on insulin pumps: Parents/guardians, as named below, are authorized *to* propose a temporary basal rate increase or decrease by____% for the duration of school time hours on that specific day, including, hours before and after school.

**If school personnel attempt to contact the parents/guardians, as named below, at the following appropriate telephone number provided by the parents/guardians on at least one occasion and the parents/guardians, as named below, are unable to be reached, and the school health professional determines using his/her professional judgment that treatment is necessary, the school health professional should follow the written orders provided by the health care provider, using his/her/their professional judgment.*

Parent/Guardian: _____ Phone: _____ Date: _____
Parent/Guardian: _____ Phone: _____ Date: _____
Parent/Guardian: _____ Phone: _____ Date: _____
Parent/Guardian: _____ Phone: _____ Date: _____

This DMP is in effect for one calendar year: _____/_____/_____ **to** _____/_____/_____

Health care provider: _____ _____/_____/____
Signature *Date*

☐ By checking this box, the provider understands that for school personnel to honor this form, the student's DMP must also be accompanied by a physician order that authorizes the school nurse to make dosage adjustments within the same range(s) authorized above for the parent/guardian to propose, so that a nurse may exercise her professional judgment, when needed.