Virginia School Diabetes Management Protocols

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I. Protocol Statement

The Virginia School Diabetes Management Protocol is a guide to be used to promote & ensure excellence, safety and support for children with diabetes in our schools. This protocol is a collaborative effort between parents/guardians, students, medical providers and school personnel.

This protocol was initially developed by the Health Services Supervisors/Coordinators of the following school districts:

- Chesapeake
- Hampton
- Newport News
- Portsmouth
- Suffolk
- Virginia Beach

Additional input and review provided by:

- Isle of Wight
- Norfolk
- Poquoson
- Williamsburg

Medical review has been provided by a multispecialty group of Pediatric Endocrinologists and Certified Diabetes Educators from:

- Animas Corporation
- Carilion Health System
  Roanoke, VA
- Children’s Hospital of The King’s Daughters
  Norfolk, VA
- Children’s National Medical Center
  Washington, DC
- Eastern Virginia Medical School
  Norfolk, VA
- Inova Diabetes Center
  Northern Virginia
- Portsmouth Naval Hospital
  Portsmouth, VA
- University of Virginia
  Charlottesville, VA
- Virginia Commonwealth University Health System/Medical College of VA
  Richmond, VA

Additional review has been provided by:

- The American Diabetes Association (national office and local affiliates)
- Virginia Department of Education
- Virginia Department of Health
II. Responsibilities for Implementation

A. Parent/Guardian Responsibilities

1. Inform the school nurse/school administrator that your child has diabetes when the student enrolls in school or is newly diagnosed.
2. Provide accurate emergency contact information and update as necessary.
3. Provide the Diabetes Medical Management Plan (DMMP), signed by your child’s medical provider and yourself to the school nurse. This plan must be renewed prior to the beginning of each school year.
4. Inform school nurse/school administrator of any changes in the student’s health status and/or DMMP.
5. Provide all supplies and equipment necessary for implementing your child’s DMMP. Replenish supplies as needed (within 48 hours of notification).
6. Inform the school nurse and other appropriate school staff when the student plans to participate in school-sponsored activities.
7. Authorize trained unlicensed school personnel to administer insulin and glucagon in the absence of a registered nurse.
8. Teach your child to:
   a. Understand age-appropriate diabetic care (refer to Student Responsibilities).
   b. Communicate clearly to adults in authority that he/she has diabetes and is not feeling well.
   c. Inform you about his/her diabetes management during the school day.
   d. Wear a medical alert ID at all times.
B. Student Responsibilities

1. Learn age-appropriate diabetic care
2. Know the following:
   a. Who to contact and what to do when having a low or high blood sugar reaction
   b. What the written school plans says to help manage your diabetes
   c. When you should check blood glucose levels, give insulin, have a snack, and eat breakfast/ lunch
   d. Where the diabetes supplies are stored, if you do not carry them, and who to contact when you need to use them
3. Take charge of your diabetes care at school as the DMMP allows. This may include:
   a. Monitoring and recording blood glucose levels
   b. Calculating accurate insulin doses
   c. Self-administration of insulin/medications
   d. Proper disposal of needles, lancets, and other supplies properly
   e. Eating meals and snacks as prescribed
   f. Treating hypoglycemia and hyperglycemia (low & high blood sugar)
   g. Carrying and using diabetes equipment and supplies as directed
4. Cooperate with school and healthcare personnel who are assisting you with & supervising your diabetes care.
C. Medical Provider Responsibilities

1. Complete and sign a *Diabetes Medical Management Plan (DMMP)* for the student prior to the beginning of each school year or anytime an update is needed.
2. Authorize trained unlicensed school personnel to administer insulin and glucagon in the absence of a registered nurse.
3. Assess student’s ability to self-carry, then complete and sign the *Self Carry Authorization Form*, if appropriate (Part 5 of the DMMP).
4. Respond to requests for assistance with medical management in a timely manner or assign appropriate staff from your practice to address school diabetes management as required.
D. School Nurse Responsibilities

1. Obtain and review the student’s current DMMP from the medical provider and pertinent information from the family.
2. Conduct a nursing assessment of the student and develop an Individualized Health Plan (IHP) as indicated (Appendix B&I).
3. Participate in the development and implementation of the student’s 504, Individualized Educational Program (IEP), or other education plan as indicated.
4. Conduct ongoing, periodic assessments of students with diabetes and update the nursing care plan.
5. Provide a Quick Reference Emergency Plan and other relevant diabetic information to staff members who have responsibility for the student throughout the school day (Appendix C&I).
6. Obtain materials and medical supplies necessary for diabetes care tasks from the parent/guardian and notify the student or parent/guardian when supplies need to be replenished (Appendix A&D).
7. Plan and implement diabetes training for the unlicensed assistive personnel (Appendix E).
8. Attend annual diabetes training.
9. Perform routine and emergency diabetes care tasks including documentation as necessary (Appendix F).
10. Promote and encourage independence and self-care consistent with the student’s ability, skill, maturity, and developmental level.
11. Act as liaison between the school and student’s health care provider/team regarding the student’s diabetes management at school with parental permission. Resources at each health care provider may differ, but you would expect the following resources to be available:
   a. Physicians, Nurse Practitioner and or Physician Assistant
   b. Nurse
   c. Dietitian
   d. Certified Diabetes Educator
   e. Social Worker
   f. Education Consultant
12. Communicate to parent/guardian concerns about the student’s diabetes management or health.
13. Respect the student’s confidentiality and right to privacy.
14. Act as an advocate for students to help them meet their diabetes health care needs.
15. Maintain current knowledge about federal, state, and local laws and regulation that pertain to managing diabetes at school.
16. Review the Nurse’s Standard File for Diabetic Students (Appendix __).
E. School Staff Responsibilities

1. Meet with the parent/guardian, to gather information related to the child’s diabetes.
2. Communicate with the school nurse regarding any concerns about the student.
3. Recognize that a change in the student’s behavior could be a symptom of blood glucose changes; be prepared to respond to the signs and symptoms of hypoglycemia and hyperglycemia.
4. Send another person to the clinic with the child if displaying signs of high or low blood sugar; **Do Not Send Alone.**
5. If a student displays symptoms of hypoglycemia, it would be preferred to provide treatment in the classroom and then notify school nurse. **Adult accompaniment is required if symptoms are present and child must leave the classroom for treatment.** If possible, school nurse/clinic should be notified that student is coming to clinic.
6. Respect the student’s confidentiality and right to privacy.
7. Provide a supportive environment for the student to manage diabetes effectively and safely at school, which may include:
   a. Eating snacks for routine diabetes management
   b. Having bathroom privileges and access to drinking water
   c. Monitoring blood glucose
   d. Administering insulin and other medications
8. Provide accommodations for the student with diabetes, as indicated in the student’s IHP, 504 plan, IEP, or other education plan (Appendix H).
9. Learn about diabetes from your school nurse.
10. Notify the parents/guardians and school nurse **in advance** of changes in school schedule, such as class parties, field trips, and other special events.
11. Provide information for substitute teachers/nurses that communicates the needs of the student.
III. Virginia School Diabetes Medical Management Plan

A. Part 1. Parent/Guardian Information includes Parent Authorizations for Trained School Designees

This form is distributed by the school nurse/clinic and is to be completed by the parent or guardian. The information in this form provides helpful information for completing the Individualized Health Plan. This form is required by the State of Virginia Board of Education as required by law to determine parent/guardian permission or denial of permission for administration of insulin and/or glucagon by trained unlicensed personnel. This form does not require any involvement from the healthcare provider’s office.

B. Part 2. Physician Orders and Authorizations

Children with diabetes receiving care at Children’s Hospital of The King’s Daughters, Portsmouth Naval Hospital and the Medical College of Virginia have agreed to use the forms included in this document. They may complete the forms electronically, in writing or a combination of both. Parents/guardians should request or obtain these completed forms from their physician and are required to sign these forms to authorize communication between the healthcare provider’s office and the school. School forms will not automatically be sent to the school without the caregivers request. The forms should then be brought to the school by the child’s caregiver. If another physician’s office prefers to use his/her own Diabetes Medical Management Plan it must include all of the elements in this form (copies of these form may be shared electronically or by printing to any healthcare provider or family). Please note that physician authorization for treatment by trained school designees must be included in the Diabetes Medical Management Plan or a separate form must be provided. Healthcare providers are aware that children may be restricted from attending school if these forms are not provided to the school, but cannot be held responsible if the forms are not delivered to the school by the caregiver. Providers may make changes to these orders during the school year and are permitted to send only the applicable page requiring changes (the entire order set is not required and new caregiver signatures are not required with changes). New forms are required on an annual basis.

C. Part 3. Plan Supplement for Student Wearing Insulin Pump

If the child wears an insulin pump this supplemental form should be completed by the physician and caregiver. Portions of this form will be completed by the parent/guardian after the healthcare provider initiates the sections requiring orders. This form has been developed to help provide information regarding the child’s proficiency in operating their insulin pump and to provide information on areas of operation where they will require assistance or supervision. Parents/caregivers are required to provide adequate instruction, manuals and supplies to support pump therapy use in the school.

D. Part 4. Permission to Self-Carry

If a child is going to carry and self administer insulin and perform blood sugar checks in the classroom; an “Authorization to Carry and Self-Administer Medication Form” must be completed by the physician, school nurse and the parent. As explained on the form, the school has the option to revoke this privilege if adherence to school rules or guidelines is not demonstrated by the student.
IV. Exercise Guidelines

Exercise and physical activity are beneficial for all children. Children who have diabetes especially benefit from exercise because physical activity can help to lower blood glucose levels. All children with diabetes can participate fully in physical education classes and team sports. In order to maintain blood glucose levels in target ranges, adjustments may need to be made to insulin and food intake. It is also important to check blood glucose levels more frequently while being active to prevent hypoglycemia.

Important Things to Know About Exercise and Diabetes
- Do NOT exercise if you have moderate or large ketones.
- Exercise may cause low blood sugars.
- The effects of exercise on blood sugar lowering can last for up to 24 hours as glycogen stores are repleted in the muscles.
- Exercise may cause high blood sugars due to adrenaline output.
- All kids should aim for at least 30 minutes of daily activity at least 5 days per week.
- Blood sugar should be checked before, during, and after activity as needed.

Suggestions for Safe Exercise in the Child with Diabetes
- Check blood sugar before exercise.
- Check ketones prior to exercise if blood sugar is >300.
- Remember that everyone reacts differently to exercise. The only way to learn how your child reacts is to check blood sugars more frequently during activity.
- Eat a snack before exercise if needed. A good rule of thumb is 15 grams of carbohydrate for every 30 minutes of vigorous activity. Protein may be needed if the activity will be continued over a longer period of time.
- Always have extra snacks on hand.
- Carry a fast acting sugar to treat hypoglycemia.
- Be sure there is a current glucagon kit handy in case of emergency.
- Do not correct a high blood sugar immediately after exercise.
- Drink extra water or sugar-free fluids before exercising. A good rule of thumb is 8 oz for every 30 minutes of vigorous activity.
- Do not exercise alone.
- Wear a diabetes ID bracelet or necklace.
- Consider the injection site and type of activity. Insulin will be absorbed more quickly if given in a spot that will be used during the activity. For example, avoid the leg if child will be running or avoid the arm if child will be playing tennis. The stomach is usually a good site for pre-exercise injections.
- Think about peak action times of insulin and adjust insulin doses as needed to prevent hypoglycemia.
### General guidelines for extra food to cover exercise

<table>
<thead>
<tr>
<th>Expected length of exercise</th>
<th>Blood sugar before exercise</th>
<th>Extra carbohydrate</th>
<th>Example of foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short (15-30 minutes)</td>
<td>Less than 80</td>
<td>15-20 grams</td>
<td>1 cup Gatorade or 1 cup milk or ½ cup juice</td>
</tr>
<tr>
<td></td>
<td>80-150</td>
<td>15 grams</td>
<td>Small piece fresh fruit</td>
</tr>
<tr>
<td></td>
<td>Greater than 150</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Moderate (30-120 minutes)</td>
<td>Less than 80</td>
<td>25-30 grams (include source of protein/fat)</td>
<td>1 cup Gatorade or 1 cup milk or ½ cup juice plus ½ sandwich</td>
</tr>
<tr>
<td></td>
<td>80-150</td>
<td>25-30 grams (include source of protein/fat)</td>
<td>1 cup Gatorade or 1 cup milk or ½ cup juice plus small piece of fruit</td>
</tr>
<tr>
<td></td>
<td>Greater than 150</td>
<td>15 grams (include source of protein /fat)</td>
<td>½ sandwich</td>
</tr>
<tr>
<td>Long (2 hours or more)</td>
<td>Less than 80</td>
<td>30-40 grams initially, then 15 grams every hour (include source of protein/fat initially)</td>
<td>4-8 oz Gatorade plus whole sandwich then 8 oz Gatorade or 4 oz juice every hour</td>
</tr>
<tr>
<td></td>
<td>80-150</td>
<td>20-30 grams initially, then 15 grams every hour (include source of protein/fat initially)</td>
<td>4-8 oz Gatorade plus ½ sandwich then 8 oz Gatorade or 4 oz juice every hour</td>
</tr>
<tr>
<td></td>
<td>Greater than 150</td>
<td>15-20 grams initially then 15 grams every hour (include source of protein/fat initially)</td>
<td>Whole sandwich then 8 oz Gatorade every hour</td>
</tr>
</tbody>
</table>

Adapted from: Understanding Diabetes, 11th Edition
V. Field Trips

A student may not be excluded from field trips and other school-sponsored activities due to his/her diabetes. The same care provided at school should travel with them on field trips.

The written documents that need to be consulted when preparing a student with diabetes for a field trip are (not every student will have all of these):

A. Diabetes Medical Management Plan (DMMP)
B. Individualized Health Plan (IHP)
C. Section 504 Plan
D. Individualized Education Program (IEP)

It is important to make provisions for field trips in one of the above documents. This would ensure a smooth and safe transition from classroom to an off-site learning environment. The provisions should include who will assist the student on the field trip with his/her diabetes care. Well in advance, a field trip schedule should be provided to the parent and school nurse.

Supply checklist for field trip (What should school personnel bring as a minimum?):

- Copy of the DMMP
- Fast-acting carbohydrate
- Blood glucose testing equipment & supplies
- Insulin & insulin delivery system (pens & pen needles, syringes, etc)
- Ketone Strips
- Glucagon Kit
- Pump supplies, if applicable
- Extra batteries for meter, pump, etc., if applicable
- Additional supplies and insulin in case of delay in returning to school
- Cell phone to call for help if needed
- Emergency contact information
VI. REFERENCES/RECOMMENDED RESOURCES


Children’s Diabetes Foundation at Denver: [www.childrensdiabetesfdn.com](http://www.childrensdiabetesfdn.com)

Children with Diabetes: [www.childrenwithdiabetes.com](http://www.childrenwithdiabetes.com)

**Diabetes Care Tasks at School: What Key Personnel Need to Know School Training Modules** (American Diabetes Association Safe at School). PowerPoint Modules may be accessed by going to [www.diabetes.org/schooltraining](http://www.diabetes.org/schooltraining)


**Manual for Training Public School Employees In the Administration of Insulin and Glucagon**, September 1999, Virginia Department of Education, division of Instruction, Office of Special Education and Student Services.

**Partners for Success: School Nurses and the Care of Children with Diabetes at School.** School of Public Health, State University of New York at Albany. DVD available from the American Diabetes Association.


*These references can be accessed online in view only format at: [www.barbaradaviscenter.org](http://www.barbaradaviscenter.org) (click on Online Books & Teaching Slides).
VII. Appendices
   A. Target Blood Glucose Goals by Age (ADA)
   B. Accommodations to Consider
   C. Checklist for Parents/School Checklist
   D. Supply List for Insulin Pumps
   E. Continuous Glucose Sensors/Continuous Glucose Monitoring Systems
   F. Quick Reference Emergency Plan for Hyper/Hypoglycemia
   G. Insulin Injection Training & Dose Calculations
   H. Hypoglycemia and Glucagon Injection Training
   I. Individualized Healthcare Plan
   J. Nurse’s Standard File for Diabetic Students
   K. Diabetes Treatment Log
   L. Documentation of Communication Checklist
   M. Forms
      1. Parent/Guardian includes Parent Authorizations for Trained School
         Designees
      2. Physician Orders and Authorizations (DMMP)
      3. Plan Supplement for Student Wearing Insulin Pump
      4. Permission to Self-Carry
A. Target Blood Glucose Goals by Age (ADA)

Table 15—Plasma blood glucose and A1C goals for type 1 diabetes by age-group

<table>
<thead>
<tr>
<th>Values by age (years)</th>
<th>Plasma blood glucose goal range (mg/dl)</th>
<th>A1C</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toddlers and preschoolers (0–6)</td>
<td>100–180</td>
<td>110–200</td>
<td>&lt;8.5% (but &gt;7.5%)</td>
</tr>
<tr>
<td>School age (6–12)</td>
<td>90–180</td>
<td>100–180</td>
<td>&lt;8%</td>
</tr>
<tr>
<td>Adolescents and young adults (13–19)</td>
<td>90–130</td>
<td>90–150</td>
<td>&lt;7.5%</td>
</tr>
</tbody>
</table>

Key concepts in setting glycemic goals:
- Goals should be individualized and lower goals may be reasonable based on benefit-risk assessment.
- Blood glucose goals should be higher than those listed above in children with frequent hypoglycemia or hypoglycemia unawareness.
- Postprandial blood glucose values should be measured when there is a discrepancy between pre-prandial blood glucose values and A1C levels.
B. Accommodations to Consider

Accommodations Recommended For Students with Diabetes

- Will be able to keep a bottle of water with them at all times
- Will be able to have unlimited access to restrooms
- Will be able to eat a snack in the classroom
- Will be able to eat snacks and meals at the same time each day, if applicable. Should there be any change in this routine, the parent will be notified
- Will be allowed to leave the classroom for diabetes related issues
- Will be accompanied when leaving the classroom, as needed
- Will have access to all diabetes related supplies
- Will be supervised by a staff member when administering insulin to verify that the correct dosage has been given
- Will be totally independent and need no adult supervision for diabetes care, including insulin calculation and injection; the physician and parent will document and sign in the diabetes plan of care to include permission for self carry
- Will be monitored in elementary school by a staff member to determine amount of food eaten and that no food is shared with other children
- Will be able to participate fully in physical education classes and other activities as determined by the DMMP
- Will be able to test their blood glucose levels before all examinations and standardized tests
- Will not be penalized for time spent on diabetes care when taking an exam or completing a classroom assignment
- Will not be penalized for diabetes related absences
C. Checklist for Parents/School Checklist

**DIABETES SCHOOL CHECKLIST**

- Read “Parental Responsibilities”
- Read and discuss “Student with Diabetes Responsibilities” with student
- Have the student’s Doctor complete the “Diabetic Medical Management Plan”, Parts I, II, and if necessary Part III (Pump Management)
- Discuss specific care of your child with the teachers, school nurse, bus driver, coaches and other staff who will be involved.
- Complete the individualized school health plan with the help of the school staff and your diabetes care team.
- Make sure your child understands the details of who will help him/her with testing, shots and treatment of high or low blood sugars at school and where supplies will be kept. Supplies should be kept in a place where they are always available if needed.
- Make arrangements for the school to send home blood sugar records Weekly (or fax to MD office).
- Keep current phone numbers where you can be reached. Complete a medical release giving the school written permission to contact the child’s healthcare provider in the event of an emergency. Complete release for administration of glucagon by trained, unlicensed personnel.
- Collect equipment / supplies for school including the following:
  - Box with the child’s name to store these items (you may need one for meds and one for food).
  - Medical Identification
  - Meter
  - Strips
  - Lancets & Device
  - Insulin
  - Syringes or pens & pen needles
  - Alcohol wipes
  - Glucagon Kit with instructions
  - Ketone testing strips
  - Sharps container
  - Log sheets for blood sugars
  - Pump supplies
  - Batteries for meter &/or pump
  - Food/Drinks for treating Low Blood Sugar
    - 15 gm CHO Juice cans or boxes
    - Glucose tabs
    - Instant glucose or cake decorating gel
    - Fruit-Roll Ups
    - Dried Fruit, raisins or other snacks
    - Crackers (± peanut butter and/or cheese)
- Check regularly to make sure school has all necessary supplies (suggest monthly as a minimum).
D. Supply List for Insulin Pumps

Supply List for Insulin Pumps

________ Blood glucose monitoring device, test strips, lancets
________ Sharps Container
________ Extra meter battery
________ Extra pump battery
________ Insulin and syringes
________ Extra infusion sets, reservoirs/cartridges and insertion device (or extra Pods)
________ Alcohol pads
________ Dressing and tape (or other adhesive)
________ Glucose tablets/instant glucose
________ Glucagon emergency kit
________ Ketone test strips
E. Continuous Glucose Sensors

Continuous Glucose Monitoring (CGM) In The School:
A continuous glucose monitor reads glucose levels from a sensor in the interstitial fluid (under the skin/subcutaneous). It usually reads within 15-20% of a finger stick blood glucose value. The monitor can be programmed to alert (vibrate or alarm audibly) for predetermined high and low glucose levels. CGM is meant to provide additional glucose information and does not take the place of finger stick blood glucose values. It is not FDA approved for use in making diabetes treatment decisions.

Always make sure that hands are clean and check a blood glucose via finger stick before performing treatment.

Alert Settings

CGM will alarm if interstitial glucose is less than _______ mg/dl or above _______.
If CGM alarms for low or high glucose levels, check finger stick blood sugar and treat according to the DMMP/Physician Orders.

Arrows

Some continuous monitors show arrows on the screen to indicate the speed at which the glucose levels are changing. Arrows on the face of the monitor may point straight down, indicating a rapidly falling glucose level. Treatment should then be as in A. 2. below. The arrows may also point straight up, which means a rapid increase in glucose level. Treatment should be as in C. Below. A horizontal or 45 degree arrow (or one arrow in contrast to two arrows) may mean that the glucose level is not changing as rapidly.

When to Use CGM Information

A. Lows or Pending Lows
1. **CGM screen shows <70 mg/dl with or without arrow(s):**
   Check finger stick blood glucose and if low proceed with physician’s care plan for treatment and food. Repeat blood glucose every 15 minutes until level is above 70 mg/dl.
2. **CGM Screen shows <100 mg/dl with downward arrow(s):**
   Check finger stick blood glucose. If blood sugar is between 70 and 100 mg/dl give 5-10 grams of carbohydrate (to prevent blood sugar from going lower). If <70 mg/dl proceed with physician’s care plan for treatment and food as above.

B. Glucose Levels in Target Range
1. **CGM screen shows 80-200 mg/dl with or without arrow(s):**
   Check finger stick blood glucose as usual per DMMP or if symptomatic.

C. Highs or Pending Highs
1. **CGM screen shows >200 mg/dl with upward arrow(s) or >250 mg/dl:**
   Check finger stick blood glucose and follow physician’s DMMP for treatment of high glucose including instructions for checking ketones, calling physician or parents and providing correction insulin.
F. Quick Reference Emergency Plan for Hyper/Hypoglycemia

Double-click on the link below (or paste the link into your web browser) to display PDF of Hypoglycemia & Hyperglycemia Flow Charts for reference or printing (page 61-62).


Quick Reference Emergency Plan
for a Student with Diabetes

Hypoglycemia
(Low Blood Sugar)

Student’s Name

Grade/Teacher

Date of Plan

Emergency Contact Information:

Mother/Guardian

Father/Guardian

Home phone

Work phone

Cell

Home phone

Work phone

Cell

School Nurse/Trained Diabetes Personnel

Contact Number(s)

Never send a child with suspected low blood sugar anywhere alone.

Causes of Hypoglycemia

• Too much insulin
• Missed food
• Delayed food
• Too much or too intense exercise
• Unscheduled exercise

Onset

• Sudden

Symptoms

Mild

• Hunger
• Shakiness
• Weakness
• Paledness
• Anxiety
• Irritability
• Dizziness

Moderate

• Headache
• Behavior change
• Poor coordination

Severe

• Loss of consciousness
• Seizure
• Inability to swallow

Actions Needed

Notify School Nurse or Trained Diabetes Personnel. If possible, check blood sugar, per Diabetes Medical Management Plan. When in doubt, always TREAT FOR HYPOGLYCEMIA.

Mild

• Student may/may not treat self.
• Provide quick-sugar source.
  3-4 glucose tablets or
  4 oz. juice or
  6 oz. regular soda or
  3 teaspoons of glucose gel
• Wait 10 to 15 minutes.
• Recheck blood glucose.
• Repeat food if symptoms persist or blood glucose is less than
• Follow with a snack of carbohydrate and protein (e.g.,
cheese and crackers).

Moderate

• Someone assists.
• Give student quick-sugar source per MILD guidelines.
• Wait 10 to 15 minutes.
• Recheck blood glucose.
• Repeat food if symptoms persist or blood glucose is less than
• Follow with a snack of carbohydrate and protein (e.g.,
cheese and crackers).

Severe

• Don’t attempt to give anything by mouth.
• Position on side, if possible.
• Contact school nurse or trained diabetes personnel.
• Administer glucagon, as prescribed.
• Call 911.
• Contact parents/guardian.
• Stay with student.
G. Insulin Injection Training & Dose Calculations

Hampton Roads Regional School Diabetes Management Protocol

*Insulin Injection Training & Dose Calculations*

Employee Receiving Training: ________________________________

School: ________________________________________________

Trainer/Evaluator: ______________________________________

<table>
<thead>
<tr>
<th>PERFORMANCE CRITERIA</th>
<th>DATE:</th>
<th>INITIALS OF EVALUATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Describes situations that insulin is necessary. States storage and security of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>insulin and syringes and medical supplies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Locates student’s care plan and determines correct insulin dose and time insulin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>is to be administered. Demonstrates ability to accurately perform insulin dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>calculations.</td>
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<td></td>
</tr>
<tr>
<td>3. States 5 “Rights” of medication administration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Accurately measures insulin dose using a syringe and an insulin pen. Practice of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 units, 5.5 units, 7 units.</td>
<td></td>
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</tr>
<tr>
<td>5. Locates injection site to be used.</td>
<td></td>
<td></td>
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<tr>
<td>6. Demonstrates accurate injection technique.</td>
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<tr>
<td>7. States precautions to take after insulin is administered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Discuss proper disposal of medical supplies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Trainer/Evaluator (signature): ___________________________ Date: __________

Employee (signature): _________________________________ Date: __________
**H. Hypoglycemia & Glucagon Training**

**Hampton Roads Regional School Diabetes Management Protocol**

**Hypoglycemia & Glucagon Training**

Employee Receiving Training: __________________________________________

School: __________________________________________________________

Trainer/Evaluator: _________________________________________________

<table>
<thead>
<tr>
<th>PERFORMANCE CRITERIA</th>
<th>DATE:</th>
<th>INITIALS OF EVALUATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Describes symptoms of hypoglycemia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Discuss appropriate treatment for mild, moderate, and severe hypoglycemia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. States situations when glucagon emergency kit should be used.</td>
<td></td>
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</tr>
<tr>
<td>4. Accurately mixes and withdraws glucagon from vial. States where to find correct glucagon dose for student (0.05 &amp; 1.0 mg).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Locates injection site to be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Demonstrates accurate injection technique.</td>
<td></td>
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<tr>
<td>7. Lists precautions to take when using glucagon: Turn on side. Check MD order for dose. Activate 911 and call school nurse and parents.</td>
<td></td>
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</tr>
<tr>
<td>8. Discuss that glucagon injection may be repeated if patient fails to respond while waiting for emergency assistance. Intravenous glucose MUST be administered if the patient fails to respond to glucagon.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Discuss that when child is able to swallow, food or fluids should be given to prevent recurrent hypoglycemia.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REMEMBER: THERE IS NO DANGER OF OVERDOSE**

**GLUCAGON CAN BE GIVEN THROUGH CLOTHING.**

Trainer/Evaluator (signature): ____________________ Date: __________

Employee (signature): ___________________________ Date: __________
I. Individualized Healthcare Plan

INDIVIDUALIZED HEALTH CARE PLAN

Below are suggested resources that can be used to develop an Individualized Health Care Plan (IHP). It is best practice to develop an IHP that includes specifics of care and addresses particulars that are not included in the DMMP, such as field trip accommodations, training of staff in diabetes, specific times to test blood sugars, etc. It is a plan that should be provided to teachers and other staff members that are directly involved with the diabetic student.


J. Nurse’s Standard File for Diabetic Students

Nurse’s Standard File for Diabetic Students

_____ Current Diabetes Medical Management Plan
_____ Current IHP, 504 and/or IEP
_____ Permission to Self Carry, if applicable
_____ Quick Reference Emergency Plan
_____ Emergency Contact Information
_____ Copy of Student’s Schedule
_____ Diabetes Treatment Log, if indicated

Other items to have on hand in the clinic:

- Quick reference chart on hyper/hypo-glycemia (to share with teachers, etc.)
- CHO Counting Reference Book
- Information on CHO counts in cafeteria foods from Food Services
- Copy of menu for the month
- Pump Reference/Manual if applicable
# Diabetes Treatment Log

## Student Information
- **Student:** __________________
- **School:** __________________
- **Grade:** ____
- **Teacher:** ____________
- **Room #: ____

**Parent/Guardian Telephone #:**
- **Home:** __________________
- **Work/Cell:** __________________

**Target Glucose:** ________________

**Signature/Title/Initials:**
- __________________
- __________________
- __________________
- __________________

## Treatment Log

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Symptoms</th>
<th>Blood Glucose</th>
<th>Ketones (Negative, Trace, small, moderate or large)</th>
<th>Carbs</th>
<th>Insulin Dose</th>
<th>Action</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

25
L. Documentation of Communication

Documentation Checklist for Information Shared with Staff Members

<table>
<thead>
<tr>
<th>Name of Student:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/Title (Print)</td>
<td>Information Provided</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

M. School Forms

1. Parent/Guardian includes Parent Authorizations for Trained School Designees
2. Physician Orders and Authorizations (DMMP)
3. Plan Supplement for Student Wearing Insulin Pump
4. Permission to Self-Carry
III. Hampton Roads Regional School Diabetes Medical Management Forms

Student ___________________________ School ___________________________ Effective Date ______________
Date of Birth _______________ Grade _______ Homeroom Teacher _______________________

Dear Parent/Guardian:

1. **Part 1**- Medical history and contact information. To be completed by parent/guardian.
   Includes: Parent authorization for trained school designees. To be completed by parent/guardian.
2. **Part 2***- Have your child’s physician complete unless the physician’s office prefers to use his/her own Diabetes Medical Management Plan. Please note that physician authorization for treatment by trained school designees must be included in the Diabetes Medical Management Plan or a separate form must be provided.
3. **Part 3***- Have the physician/diabetes educator/caregiver complete if your child wears an insulin pump.
4. **Part 4**- If your child is going to carry and self administer insulin and perform blood sugar checks in the classroom; an “Authorization to Carry and Self-Administer Medication Form” must be completed by the physician, school nurse and the parent.

*Other Diabetic Medical Management Plans may be used for Parts 2 & 3 as long as all components are represented.

Return completed forms to the school nurse as quickly as possible. Thank you for your cooperation.

School nurse __________________________________ Phone ___________ Date ___________

Please note: during the school year, in order to change your child’s diabetes care at school, an updated physician’s order must be submitted to the school nurse.

**Part 1: Parent/Guardian to complete:**

**Contact Information:**

Parent/Guardian #1:
Address: ____________________________________________________________
Telephone-Home: ___________________ Work: ___________________ Cell: ___________________

Parent/Guardian #2:
Address: ____________________________________________________________
Telephone-Home: ___________________ Work: ___________________ Cell: ___________________

Other emergency contact: ____________________________________________ Relationship: ___________
Address: ____________________________________________________________
Telephone-Home: ___________________ Work: ___________________ Cell: ___________________

Physician managing diabetes: __________________________________________
Address: ____________________________________________________________
Main Office #: ___________ Fax #: ___________ Emergency Phone #: ___________

Nurse/Diabetes Educator ______________________________________________ Work #: ___________

**Diabetes Questions**

**Parent/Guardian Response (check appropriate boxes and complete blanks)**

<table>
<thead>
<tr>
<th>Diagnosis information</th>
<th>At what age?</th>
<th>Type of diabetes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often is child seen by this physician?</td>
<td>Include date last seen.</td>
<td></td>
</tr>
<tr>
<td>Nutritional needs</td>
<td>Snack</td>
<td>AM PM Prior to Exercise/Activity</td>
</tr>
<tr>
<td></td>
<td>Only in case of low blood glucose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student may determine if CHO counting</td>
<td></td>
</tr>
</tbody>
</table>
In the event of a class party, may eat the treat (include insulin coverage if indicated in medical orders)
- student able to determine whether to eat the treat
- replace with parent supplied treat
- may NOT eat the treat
- other

<table>
<thead>
<tr>
<th>Child’s most common signs of low blood glucose</th>
<th>☐ trembling</th>
<th>☐ tingling</th>
<th>☐ loss of coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ dizziness</td>
<td>☐ moist skin/sweating</td>
<td>☐ confusion</td>
<td></td>
</tr>
<tr>
<td>☐ heart pounding</td>
<td>☐ hunger</td>
<td>☐ seizure</td>
<td></td>
</tr>
<tr>
<td>☐ weakness</td>
<td>☐ fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ pale skin</td>
<td>☐ headache</td>
<td>☐ unconsciousness</td>
<td></td>
</tr>
<tr>
<td>☐ change in mood or behavior</td>
<td>☐ other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Trembling
- Tingling
- Loss of coordination
- Dizziness
- Moist skin/sweating
- Confusion
- Heart pounding
- Hunger
- Seizure
- Weakness
- Fatigue
- Unconsciousness
- Pale skin
- Headache
- Slurred speech
- Change in mood or behavior

How often does child experience low blood glucose and how severe?
- Mild
  - Indicates once a day
  - Once a week
  - Once a month
- Severe (i.e. unconscious, unable to swallow, seizure, or needed Glucagon)
  - Include date(s) of last mild episode(s)
  - Include date(s) of recent episode(s)

Episode(s) of ketoacidosis
- Include date(s) of recent episode(s)

Field trips
- Parent/guardian will accompany child during field trips?
  - YES
  - NO
  - Yes, if available

Serious illness, injuries or hospitalizations this past year
- Include date(s) and describe

List any other medications currently being taken

Allergies (include foods, medications, etc):

Other concerns and comments

I give permission to the school nurse and designated school personnel*, who have been trained and are under the supervision of the school nurse to perform and carry out the diabetes care tasks as outlined in my child’s Diabetes Medical Management Plan as ordered by the physician. I give permission to the designated school personnel, who have been trained to perform the following diabetes care tasks for my child. (Code of Virginia § 22.1-274).

- Insulin Administration: ☐ YES ☐ NO
- Glucagon Administration: ☐ YES ☐ NO

I understand that I am to provide all supplies to the school necessary for the treatment of my child’s diabetes. I also consent to the release of information contained in the Diabetes Medical Management Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child’s health and safety. I also give permission to contact the above named physician and members of the diabetes management team regarding my child’s diabetes should the need arise.

Parent/Guardian Name ___________________________ Date ______________
Parent/Guardian Signature ___________________________ ___________________________

School Nurse’s Name ___________________________ Date ______________
School Nurse’s Signature ___________________________

*Note: If at any time you would like to have the names of the designated school personnel that have been trained, please contact the school nurse. Names and training records are kept in the school clinic.
Part 2: Virginia Diabetes Medical Management Plan (DMMP)

All schools in the following School Districts will accept these forms: Chesapeake, Hampton, Isle of Wight, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach, and Williamsburg

Notice to Parents: Medication(s) MUST be brought to school by the PARENT/LEGAL GUARDIAN in a container that is appropriately labeled by the pharmacy or physician/practitioner.

It is desirable that medication not be administered during school hours. However, in order for schools to safely administer medication during school hours, the following regulations should be observed:

1. Written orders using this form from a physician, nurse practitioner, physician assistant or dentist must detail the name of the drug, the dosage, and the interval of medication administration.
2. The parent/legal guardian requesting that the school district comply with the physician/nurse practitioner/dentist's order must review the form with provider and school officials and sign the form.
3. Unopened, over-the-counter medication can be labeled by the school nurse if all other criteria for administration of the medication are stated.
4. A new copy of the DMMP must be completed at the beginning of each school year. This form, an Authorization for Medication Administration form, or MD prescription must be received in order to change diabetes care at school during the school year.

Student Name (Last, First, MI)  Student’s Date of Birth
School  Student’s Grade  Grade  Home Phone
Parent Name  Work/Cell Phone
Home Address  City  State, Zip code
Student’s Diagnosis:  DIABETES:  ☒ Type 1  ☐ Type 2  Today’s Date  4/19/2013

**MONITORING**

**BLOOD GLUCOSE (BG)**
- Monitoring with meter, lancets, lancing device, and test strips
- Yes  ☐ No  ☐ Permission to Self-Carry
- ☐ Before meals
- ☐ PRN for symptoms of hypo/hyperglycemia & anytime the student does not feel well
- ☐ Before PE/Activity
- ☐ After PE/Activity
- ☐ Additional BG monitoring may be performed at parent’s request

**URINE/BLOOD KETONE TESTING**
- Anytime the BG > 300 mg/dL or when student complains of nausea, vomiting, abdominal pain
- Moderate or large ketones: Immediately call 866-883-9886.
- Trace or small ketones: increase fluids

**NAME OF MEDICATION**  **DOSE/ROUTE**  **TIME**

| GLUCAGON - INJECTABLE | 0.5 mg subq/IM 1.0 mg subq/IM | STAT for severe hypoglycemia, loss of consciousness or seizure |
| GLUCOSE TABLETS or LIFE SAVER® CANDIES or JUICE/SODA or GLUCOSE GEL | 3-4 GLUCOSE TABLETS 6 LIFE SAVER® CANDIES 4 OUNCES JUICE/SODA 1 SMALL TUBE | Anytime BG is < 80 mg/dL and conscious – follow attached Diabetes Plan for Hypoglycemia |

Specific duration of order: 2008-2009 SCHOOL YEAR

Physician Signature:  Provider Printed Name:  Kent Reifschneider, MD

Office Phone: 757-668-7237  Office Fax: 757-668-8215

Emergency # 866-883-9886  Date: 04/19/2013

I hereby give permission for the school to monitor my child’s diabetes and to administer the medications as prescribed in these orders. I also give permission for the school to contact the above health care provider regarding these orders and administration of these medications.

Parent/Legal Guardian Signature:

CHKD Form 2099 MR Rev 7/08  FDB: Diabetes Center
**Definitions**

<table>
<thead>
<tr>
<th>Insulin-to-Carbohydrate Ratio (CHO Ratio)</th>
<th>Insulin Sensitivity (Correction Factor)</th>
<th>Target Blood Glucose</th>
</tr>
</thead>
<tbody>
<tr>
<td>• the amount of insulin necessary to prevent hyperglycemia after ingestion of a specified amount of carbohydrate.</td>
<td>• the predicted drop in blood glucose concentration after administration of 1 unit of regular or rapid-acting insulin.</td>
<td>• a specific blood glucose value used to determine the correction dose of insulin administered with a meal.</td>
</tr>
<tr>
<td>• usually expressed as “1 unit for every ____ grams of carbohydrate”</td>
<td>• usually expressed as “1 unit for every ____mg/dl blood glucose is &gt; target”</td>
<td></td>
</tr>
</tbody>
</table>

**INSLIN**

**Rapid-acting Insulin Type:** Humalog®

(all doses to be administered subcutaneously)

**Lantus®** _____ units at _____ am or pm

may mix with rapid-acting insulin

(all doses to be administered subcutaneously)

**Timing of Insulin Dose:**

Rapid-acting Insulin should always be given prior to meals, snacks.

If CHO intake can be predetermined, if CHO intake cannot be predetermined insulin should be given no more than 30 minutes after completion of meal/snack.

Treat hypoglycemia before administration of meal or snack insulin.

**Dosage:** According to CHO ratio and Correction Factor (if needed) - the student requires meal time coverage with rapid-acting insulin based on the amount of carbohydrates in meal and may require additional insulin to correct blood glucose to the desired range according to the following formula:

\[
\text{Mealtime insulin} = \left(\frac{\text{Pre-meal BG} - \text{Target pre-meal BG}}{\text{Correction Factor/Sensitivity}}\right) + \left(\frac{\# \text{carbohydrates consumed}}{\text{CHO Ratio}}\right)
\]

**Target pre-meal BG:** 120

**Correction Factor/Sensitivity:** 1 unit for every 50 > 120

**CHO Ratio:** 1:15

**Exercise/PE CHO Ratio:** NA

**Correction insulin to be administered for elevated blood glucose if 3 hours or more after last insulin dose**

- Fractional amounts of insulin from correction and carbohydrate calculation, when added together, may yield an even amount of insulin.
- If uneven, then round to the nearest half unit (May use clinical discretion; if physical activity follows meal, then may round down).
- If on insulin pump, use calculation result provided by pump calculator for doses unless set or pump malfunction occurs.
- A weaker CHO Ratio may be required with meals prior to physical activity in order to prevent hypoglycemia. If so, the Exercise/PE CHO Ratio should be used instead of the CHO Ratio.

**Snacks**

- In general, children with diabetes managed using Intensive Therapy/MDI do not require snacks.
- Scheduled snacks may be required prior to or after exercise in order to prevent hypoglycemia. Insulin is not administered with these snacks.
- Before Exercise
- After Exercise

- Foods may be eaten at unscheduled times. Insulin may be ordered for these snacks in order to prevent post-meal hyperglycemia (see above).
- Snack time insulin = # carbohydrates consumed/CHO Ratio.
- Never provide insulin coverage for carbohydrate/glucose being used to treat hypoglycemia.

**Exercise and Sports**

- In general, there are no restrictions on activity.
- A student should not exercise if his/her blood glucose is < 80 mg/dL or > 300 mg/dL (with positive ketones) immediately prior to exercise or until hypoglycemia/hyperglycemia is resolved.
- A source of fast-acting glucose should be available in case of hypoglycemia.

**Specific Instructions:**

<table>
<thead>
<tr>
<th>Specific duration of order: 2008-2009 SCHOOL YEAR</th>
<th>Physician Signature:</th>
<th>Provider Printed Name:</th>
<th>Office Phone: 757-668-7237</th>
<th>Office Fax: 757-668-8215</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHKD Form 2099 MR Rev 7/08</td>
<td>Eric Gyuricsko, MD</td>
<td>Emergency # 866-883-9886</td>
<td>FDB: Diabetes Center</td>
<td></td>
</tr>
</tbody>
</table>
SCHOOL YEAR 2008-2009 DIABETES SCHOOL CARE PLAN for  
DIABETES MANAGEMENT STANDARD PRACTICE  
Effective date: 4/19/2013

Hypoglycemia (Low Blood Sugar)
Hypoglycemia is defined as a blood glucose < 70 mg/dL

Signs of hypoglycemia:

<table>
<thead>
<tr>
<th>Shakiness</th>
<th>Sweating</th>
<th>Paleness</th>
<th>Dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>Anger</td>
<td>Fighting</td>
<td>Crying</td>
</tr>
<tr>
<td>Day-dreaming</td>
<td>Inability to concentrate</td>
<td>Passing-out</td>
<td>Seizure</td>
</tr>
</tbody>
</table>

- If hypoglycemia is suspected, check the blood glucose concentration.

Management of Hypoglycemia

If student unconscious, semi-conscious (unable to control his/her airway), or seizing, administer glucagon:
- Place student in the “recovery position.”
- If glucagon is administered, call 911 for emergency assistance, and call Parents/Legal Guardian.

If conscious & able to swallow, immediately give 15 gram fast-acting glucose:
- 3-4 glucose tablets or
- 6 Life Saver® Candies or
- 6 ounces of regular soda/juice or
- 1 small tube Glucose/Cake Mate® gel

Repeat BG check in 15 minutes
- If BG still low, then re-treat with 15 gram CHO
- If BG in acceptable range and at lunch or snack time, let student eat and cover CHO per orders
- If BG in acceptable range and not lunch or snack time, provide student slowly-released CHO snack (3-4 peanut butter or cheese crackers)

If unable to raise the BG > 70 mg/dL despite fast-acting glucose sources, call 866-883-9886.

Hyperglycemia (High Blood Sugar)
Hyperglycemia is defined as a blood glucose above the blood glucose target

Signs of hyperglycemia:

<table>
<thead>
<tr>
<th>Extreme thirst</th>
<th>Frequent urination</th>
<th>Hunger</th>
<th>Headache</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>Hyperactivity</td>
<td>Dizziness</td>
<td>Stomach ache</td>
</tr>
</tbody>
</table>

- If hyperglycemia is suspected, check the blood glucose concentration.

Management of Hyperglycemia

If BG > 300 mg/dL, or when child complains of nausea, vomiting, and/or abdominal pain, ask the student to check his/her urine for ketones

- If urine ketones are trace or negative, give 8-16 ounces of sugar-free fluid (water)
- If correction insulin has not been administered within 3 hours, provide correction insulin according to student’s Correction Factor and Target pre-meal BG
- Recheck BG and ketones 2 hours after administering insulin

- If urine ketones are moderate/large, give 8-16 ounces of sugar-free fluid (water) and call 866-883-9886 for instructions concerning insulin administration.
- Contact the Parent/Legal Guardian.
- Recheck BG and ketones 2 hours after administering insulin

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations.

School plan ordered by:
Provider: Eric Gyuricsko, MD
Provider Printed Name: Eric Gyuricsko, MD
Date: 04/19/2013

Acknowledged and received by:
Parent/Legal Guardian:
Date:

Acknowledged and received by:
School Representative:
Date:
Part 2: Virginia Diabetes Medical Management Plan (DMMP)
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7. Unopened, over-the-counter medication can be labeled by the school nurse if all other criteria for administration of the medication are stated.
8. A new copy of the DMMP must be completed at the beginning of each school year. This form, an Authorization for Medication Administration form, or MD prescription must be received in order to change diabetes care at school during the school year.

<table>
<thead>
<tr>
<th>Student Name (Last, First, MI)</th>
<th>Student’s Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>Student’s Grade:</td>
</tr>
<tr>
<td></td>
<td>Home Phone</td>
</tr>
<tr>
<td>Parent Name</td>
<td>Work/Cell Phone</td>
</tr>
<tr>
<td>Home Address</td>
<td>City</td>
</tr>
<tr>
<td></td>
<td>State, Zip code</td>
</tr>
<tr>
<td>Student’s Diagnosis:</td>
<td></td>
</tr>
<tr>
<td>DIABETES:</td>
<td>□ Type 1 □ Type 2</td>
</tr>
<tr>
<td>□ Other</td>
<td></td>
</tr>
<tr>
<td>Today’s Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4/19/2013</td>
</tr>
</tbody>
</table>

**MONITORING**

**BLOOD GLUCOSE (BG) MONITORING** with meter, lancets, lancing device, and test strips

- Yes
- No
- Student requires supervision
- Before meals
- PRN for symptoms of hypo/hyperglycemia & anytime the student does not feel well
- Before PE/Activity
- After PE/Activity
- Additional BG monitoring may be performed at parent’s request

**URINE/BLOOD KETONE TESTING**
Anytime the BG > 300 mg/dL or when student complains of nausea, vomiting, abdominal pain

- Moderate or large ketones: Immediately call 866-883-9886.
- Trace or small ketones: increase fluids

**NAME OF MEDICATION**

<table>
<thead>
<tr>
<th>GLUCAGON - INJECTABLE</th>
<th>DOSE/ROUTE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5 mg subq/IM</td>
<td>STAT for severe hypoglycemia, loss of consciousness or seizure</td>
<td></td>
</tr>
<tr>
<td>1.0 mg subq/IM</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GLUCOSE TABLETS or LIFE SAVER® CANDIES or JUICE/SODA or GLUCOSE GEL</th>
<th>DOSE/ROUTE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-4 GLUCOSE TABLETS</td>
<td></td>
<td>Anytime BG is &lt; 80 mg/dL and conscious – follow attached Diabetes Plan for Hypoglycemia</td>
</tr>
<tr>
<td>6 LIFE SAVER® CANDIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 OUNCES JUICE/SODA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 SMALL TUBE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specific duration of order:
2008-2009

SCHOOL YEAR

Physician Signature: Eric Gyuricsko, MD

Provider Printed Name: Eric Gyuricsko, MD

Office Phone: 757-668-7237
Office Fax: 757-668-8215

Emergency # 866-883-9886

I hereby give permission for the school to monitor my child’s diabetes and to administer the medications as prescribed in these orders. I also give permission for the school to contact the above health care provider regarding these orders and administration of these medications.

Parent/Legal Guardian Signature:

Date: 04/19/2013
**SCHOOL YEAR 2008-2009 DIABETES SCHOOL CARE PLAN**

**CONVENTIONAL THERAPY OR TYPE 2 DIABETES**

Effective date: 4/19/2013

**Blood Glucose:** Target range for blood glucose: 80 mg/dL to 150 mg/dL

### INSULIN

<table>
<thead>
<tr>
<th>Insulin Types:</th>
<th>Insulin to be given during school hours:</th>
<th>Yes</th>
<th>No</th>
<th>Student can administer his/her own insulin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid-acting Insulin Type: <strong>NovoLog</strong>®</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-acting Insulin Type: <strong>Regular</strong></td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate-acting Insulin Type: <strong>NPH</strong></td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-acting Insulin Type: <strong>Lantus®</strong> units at am or pm</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ may mix with rapid or short-acting insulin</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Meal Plan:**

- according to the following distribution:
  - Breakfast: ____ grams
  - AM Snack: ____ grams
  - Lunch: ____ grams
  - PM Snack: ____ grams

- Insulin:CHO Ratio: 1 unit for every ____ grams of CHO
- decrease by 1 unit if pre-lunch reading is less than 80 mg/dL or if strenuous exercise if anticipated.

- Sliding scale to be administered at ____ (times)

  If blood glucose give
  ______________________ give
  ______________________ give
  ______________________ give
  ______________________ give
  ______________________ give
  ______________________ give

- Insulin Sensitivity (Correction Factor) to be administered at ____ (times)

  - the predicted drop in blood glucose concentration after administration of 1 unit of regular or rapid-acting insulin
  - usually expressed as “1 unit for every ____mg/dl blood glucose is > target”
  - If uneven, then round to the nearest whole unit (May use clinical discretion; if physical activity follows meal, then may round down)

  Sensitivity: ____
  Target: ____

### ORAL MEDICATIONS

<table>
<thead>
<tr>
<th>NAME OF MEDICATION</th>
<th>DOSAGE</th>
<th>TIME</th>
<th>POSSIBLE SIDE EFFECTS</th>
<th>TREATMENT SIDE EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Glucophage® (Metformin)</strong></td>
<td>_____ mg po</td>
<td>_____ AM or PM</td>
<td>Nausea/vomiting, diarrhea</td>
<td>Clear liquids</td>
</tr>
</tbody>
</table>

- to be administered at school

- Other: ______

### Exercise and Sports

- In general, there are no restrictions on activity.
- A student should not exercise if his/her blood glucose is <100 mg/dL or > 300 mg/dL and ketones are positive.
- A source of fast-acting glucose should be available in case of hypoglycemia.

---

**Specific duration of order:**

2008-2009

**SCHOOL YEAR**

**Physician Signature:** Eric Gyuricsko, MD

**Provider Printed Name:**

**Office Phone:** 757-668-7237

**Office Fax:** 757-668-8215

**Emergency # 866-883-9886**

** CHKD Form 2100 MR Rev 7/08 FDB: Diabetes Center**
Hypoglycemia (Low Blood Sugar)
Hypoglycemia is defined as a blood glucose < 80 mg/dL

Signs of hypoglycemia:

<table>
<thead>
<tr>
<th>Shakiness</th>
<th>Sweating</th>
<th>Paleness</th>
<th>Dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>Anger</td>
<td>Fighting</td>
<td>Crying</td>
</tr>
<tr>
<td>Day-dreaming</td>
<td>Inability to concentrate</td>
<td>Passing-out</td>
<td>Seizure</td>
</tr>
</tbody>
</table>

- If hypoglycemia is suspected, check the blood glucose concentration.

Management of Hypoglycemia

If student unconscious, semi-conscious (unable to control his/her airway), or seizing, administer glucagon.
- Place student in the “recovery position.”
- If glucagon is administered, call 911 for emergency assistance, and call Parents/Legal Guardian.

If conscious & able to swallow, immediately give 15 gram fast-acting glucose:
- 3-4 glucose tablets or
- 6 Life Saver® Candies or
- 6 ounces of regular soda/juice or
- 1 small tube Glucose/Cake Mate® gel

Repeat BG check in 15 minutes
- If BG still low, then re-treat with 15 gram CHO
- If BG in acceptable range and at lunch or snack time, let student eat and cover CHO per orders
- If BG in acceptable range and not lunch or snack time, provide student slowly-released CHO snack (3-4 peanut butter or cheese crackers)

If unable to raise the BG > 70 mg/dL despite fast-acting glucose sources, call 866-883-9886.

Hyperglycemia (High Blood Sugar)
Hyperglycemia is defined as a blood glucose above the blood glucose target

Signs of hyperglycemia:

<table>
<thead>
<tr>
<th>Extreme thirst</th>
<th>Frequent urination</th>
<th>Hunger</th>
<th>Headache</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>Hyperactivity</td>
<td>Dizziness</td>
<td>Stomach ache</td>
</tr>
</tbody>
</table>

- If hyperglycemia is suspected, check the blood glucose concentration.

Management of Hyperglycemia

If BG > 300 mg/dL, or when child complains of nausea, vomiting, and/or abdominal pain, ask the student to check his/her urine for ketones

- If urine ketones are trace or negative, give 8-16 ounces of sugar-free fluid (water)
- If correction insulin has not been administered within 3 hours, provide correction insulin according to student’s Correction Factor and Target pre-meal BG
- Recheck BG and ketones 2 hours after administering insulin

- If urine ketones are moderate/large, give 8-16 ounces of sugar-free fluid (water) and call 866-883-9886 for instructions concerning insulin administration.
- Contact the Parent/Legal Guardian.
- Recheck BG and ketones 2 hours after administering insulin

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations.

School plan ordered by:
Provider: Eric Gyuricsko, MD
Provider Printed Name: Eric Gyuricsko, MD
Date: 04/19/2013

Acknowledged and received by:
Parent/Legal Guardian:
Date:

Acknowledged and received by:
School Representative:
Date:
Part 3: Plan Supplement for Student Wearing Insulin Pump  

**Effective date: 4/19/2013**

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

**Pump Brand/Model:** Animas One Touch Ping™  
**Pump Company Technical Assistance Number:** Animas 1-877-937-7867

**Child-Lock On?**  
□ Yes □ No  
**Code:** _17_ (applicable to Cozmo Deltec™ Pump only)  
**How long has student worn an insulin pump?**  
□ New

**INSULIN / PUMP SETTINGS**

- **Rapid-acting Insulin Type:** NovoLog®

- **Use pump bolus calculator to determine all meal, snack and correction doses unless set or pump malfunction occurs.**

**Timing of Insulin Dose (Bolus Insulin):**

- Rapid-acting Insulin should always be given prior to  
  □ meals  
  □ snacks

- If CHO intake cannot be predetermined:  
  Treat hypoglycemia before administration of meal/snack.

**Dosage:** According to CHO ratio and Correction Factor (if needed) - the student requires meal time coverage with rapid-acting insulin based on the amount of carbohydrates in meal and may require additional insulin to correct blood glucose to the desired range according to the following formula:

\[
\text{Mealtime insulin} = \left( \frac{\text{Pre-meal BG} - \text{Target pre-meal BG}}{\text{Correction Factor}} \right) + \left( \frac{\# \text{ carbohydrates consumed}}{\text{CHO Ratio}} \right)
\]

**Target pre-meal BG:**

**Correction Factor/Sensitivity:**

**CHO Ratio:**

**Exercise/PE CHO Ratio:**

**Extra pump supplies will be furnished by parent/guardian:**  
□ infusion sets  
□ reservoirs  
□ pods for OmniPod™  
□ dressing/tape  
□ insulin  
□ syringes/insulin pen  
□ pump manufacturer instructions

<table>
<thead>
<tr>
<th>STUDENT PUMP SKILLS</th>
<th>NEEDS HELP?</th>
<th>COMMENTS (training to be provided by parent. School personnel will not perform pump operation without training):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Counting carbohydrates.</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>2. Giving correct bolus for carbohydrates consumed.</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>3. Calculating and administering correction bolus.</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>4. Recognizing signs/symptoms of site infection.</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>5. Disconnecting pump if needed.</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>6. Reconnecting pump at infusion set/site.</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>7. Giving injection with syringe or pen, if needed.</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>8. Accessing bolus history on pump.</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>9. Troubleshooting alarms and malfunctions.</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

**Is child competent & independent with the following pump skills?**

- **Student must be independent to be permitted to perform these tasks at school. School nurses/personnel are not routinely trained on these skills. If child is not independent, parent/guardian to be contacted for set change. Insulin by injection until set is changed per orders. If administering via injection, pump must be suspended or disconnected unless ordered otherwise.**

| 1. Prepare reservoir and tubing. | □ Yes □ No | **Comments:** |
| 2. Insert new infusion set. | □ Yes □ No | |
| 3. Use & programming of square/extended/dual/ combo bolus features. | □ Yes □ No | |
| 4. Use and programming of temporary basals for exercise and illness. | □ Yes □ No | |
| 5. Re-program basal profiles and other pump settings if needed. | □ Yes □ No | |

**Specific duration of order:**  
2008-2009 SCHOOL YEAR

**Physician Signature:**  
Eric Gyuricsko, MD

**Provider Printed Name:**  
Provider Printed Name:

**Office Phone:** 757-668-7237
**Office Fax:** 757-668-8215

**Emergency #** 866-883-9886

**FDB: Diabetes Center**
Part 3: Plan Supplement for Student Wearing Insulin Pump continued

Student Name:

**MANAGEMENT OF HIGH BLOOD GLUCOSE:** Follow instructions in diabetes medical management plan (DMMP), but in addition:

If blood glucose over target range 2 hours hours after last bolus or carbohydrate intake, student should receive a correction bolus of insulin using formula (Pump Bolus Wizard®/insulin calculator should be used unless inoperable):

\[
\text{Blood glucose} - \text{target BG} \div \text{correction factor/sensitivity} = \text{_____ units insulin}
\]

**KETONE TREATMENT TREE**

- Check for ketones any time blood sugar is >300 mg/dL or >250 mg/dL two times in a row

  - If ketones negative:
    - Bolus via pump
    - Recheck in 2 hours
  
  - If ketones present:
    - Give injection (do not use pump to bolus), change set, and call 866-883-9886 if moderate or large ketones
    - Drink 8-16 oz. sugar-free fluids (water) every hour until ketones clear
    - Recheck ketones and blood sugar every 2 hours
    - Repeat insulin injection every 2 hours until ketones clear

Inform parent of hyperglycemia treatment.

**MANAGEMENT OF LOW BLOOD GLUCOSE:** Follow instructions in DMMP, but in addition:

If blood glucose <70 mg/dL recurs within 3 hours without explanation, notify diabetes provider for instructions. Always treat low blood sugar.

**If seizure or unresponsiveness occurs:**

1. **Treat with Glucagon** (See Diabetes Medical Management Plan)
2. **Call 911** (or designate another individual to do so)
3. **Stop insulin pump** by any of the following methods (Send pump with EMS to hospital):
   - Placing in “suspend” or stop mode (See attached copy of manufacturer’s instructions)
   - Disconnecting at site, pigtail or clip
   - Cutting tubing
4. Notify parent
5. If pump was removed, send with EMS to hospital

**ADDITIONAL TIMES TO CONTACT PARENT**

- Soreness, redness or bleeding at infusion site
- Detachment of dressing/infusion set out of place
- Leakage of insulin (insulin smells like band-aids)
- Insulin injection given for high BG/ketones

**Pump Company Names & Contact Numbers (for technical assistance only)**

<table>
<thead>
<tr>
<th>Pump Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medtronic MiniMed™</td>
<td>1-800-646-4633</td>
</tr>
<tr>
<td>OmniPod/Insulet™</td>
<td>1-800-591-3455</td>
</tr>
<tr>
<td>Deltec/Cozmo™</td>
<td>1-800-426-2448</td>
</tr>
<tr>
<td>Roche/Disetronic™</td>
<td>1-800-703-3476</td>
</tr>
</tbody>
</table>

**Patient is new to pump therapy and is to initiate on ____________________ (date)**

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations.

<table>
<thead>
<tr>
<th>School plan reviewed by:</th>
<th>Provider Printed Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Signature:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eric Gyuricsko, MD</td>
<td>04/19/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acknowledged and received by:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Legal Guardian:</td>
<td></td>
</tr>
<tr>
<td>School Representative:</td>
<td></td>
</tr>
</tbody>
</table>
**Part 4: Permission to Self-Carry**

Name of Student: _____  Birthdate: _____

Student’s physician or licensed nurse practitioner confirms that the student has a diagnosis of diabetes, is independent and can perform diabetes care, has approval to self-administer his/her diabetes care including:

- glucose monitoring
- insulin calculation and administration (including pump operation & pump equipment)

The student understands that he/she is to promptly report to the school nurse or adult as soon as symptoms of high or low blood sugar appear or when not feeling well.

I agree to prepare a written Diabetes Medical Management Plan in consultation with student’s parents and appropriate school personnel.

______________________________________________________________  ______________________
Stephanie Jenney, CPNP  Date: 4/19/2013

My child has been instructed in and understands his/her diabetic self-management. My child understands that he/she is responsible and accountable for carrying and using his/her medication and equipment.

I will provide the school nurse/school administrator with a copy of my child’s Diabetes Medical Management Plan signed by his/her physician.

I hereby give permission for the school to administer the medications as prescribed in the care plan, if indicated.

I also give permission for the school to contact the above physician/nurse practitioner regarding my child’s diabetes care (authorization required if contact is other than the school nurse).

I will not hold the school board or any of its employees liable for any negative outcomes resulting from the self-administration of diabetes medication by my child.

I understand that the school nurse, after consultation with the parent/guardian and school administrator, may impose reasonable limitations or restrictions upon my child’s possession and self-administration of diabetes medications relative to his/her age and maturity or other relevant considerations.

I understand that the school administration may revoke permission to possess and self-administer said diabetes medication at any point during the school year if it is determined that my child has abused the privilege of possession and self-administration or he/she is not safely and effectively self-administering the medication. In addition, my child could be subject to further disciplinary action.

______________________________________________________________  ______________________
Parent/Guardian Signature  Date

______________________________________________________________  ______________________
Student Signature  Date