RCSD ROSEVILLE CITY SCHOOL DISTRICT Est. 1869

Diabetes Medical Management Plan

Demographic and Insulin Delivery Information:					
Student Name:		**DOB:**		**MRN:**	
Date of Diagnosis:		**Allergies:**			

Insulin Delivery Information:

Type of Insulin: *(select all that apply)*

☐ Novolog ☐ Humalog ☐ Apidra ☐ Aspart ☐ Fiasp ☐ Admelog ☐ Lispro
☐ Lantus ☐ NPH ☐ Other:_____

Insulin Delivery System:

☐ Pump ☐ Pen ☐ InPen ☐ Vial & Syringe ☐ Other:_____

Pump Type: *(if applicable)*

☐ MiniMed 780G ☐ MiniMed 770G ☐ Omnipod 5 ☐ Omnipod Dash ☐ t:slim X2
☐ Tandem ☐ Other:_____

Insulin to Carbohydrate Ratios:

Meal time insulin dose to be given pre-meal unless alternative checked: ☐ post-meal ☐ either pre-meal or post-meal

Sliding Schedule: *DO NOT GIVE IF WITHIN 3 HOURS OF PREVIOUS BLOOD GLUCOSE (BG) CORRECTION DOSE*

REQUIRED FOR EMERGENCY SITUATIONS EVEN IF THE STUDENT HAS A PUMP

____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl **Sliding scale is based on correction factor of:** _____ units/_____ mg/dl BG greater than _____mg/dl	____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl **Sliding scale is based on correction factor of:** _____ units/_____ mg/dl BG greater than _____mg/dl	____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl ____ units if BG is ____ to ____mg/dl **Sliding scale is based on correction factor of:** _____ units/_____ mg/dl BG greater than _____mg/dl
Before School Meal	Lunch	After School Meal
Insulin=_____units/____g of carbs	Insulin=_____units/_____g of carbs	Insulin=_____units/_____g of carbs

☐ Use this dose if insulin is used to cover snacks: Insulin dose=_____units/ _____grams of carbohydrates
☐ Do not use insulin to cover snacks

School Nurse (Licensed RN) may decrease or increase total insulin dosage up to (+/-) 1 unit.

Continuous Glucose Monitoring (CGM):

Does the student have a continuous glucose monitor (CGM)? ☐ No ☐ Yes

Type of CGM: ☐ Dexcom G6 ☐ Dexcom G7 ☐ Freestyle Libre ☐ Medtronic Guardian 4 ☐ Other:_____

For Dexcom G6 & G7, Medtronic Guardian 4, or sensors which need no calibration:

Dosing and treatment be provided off of CGM reading, without finger stick glucose checks: ☐ Yes ☐ No

- If symptoms of student do not match readings of CGM, a finger stick check will be completed with a glucose monitor
- Calibration may be completed, as applicable, during school hours
- **NOTE: For ALL OTHER CGM'S, decisions are made on Blood Glucose level regardless of CGM reading.**

Physical Activity:

For pre-activity BG check, if student's BG level is between 80-120 mg/dl, please provide the following amount of carbohydrates prior to exercise: ☐ 5g carbs ☐ 10g carbs ☐ 15g carbs

If a student's BG is below 80 mg/dl, DO NOT participate in activity and follow hypoglycemia protocol.

Should the student's pump be set to activity mode before or during physical activity? ☐ No ☐ During Activity ☐ Before Activity

RCSD ROSEVILLE CITY SCHOOL DISTRICT

Diabetes Medical Management Plan

HYPOGLYCEMIA (Low Blood Sugar)

If the student's CGM and/or pump BG reading is between 80-100 mg/dl and trending down can the student receive 10g of carbohydrates or less?	☐ Yes	☐ No
• **If student's blood glucose is < 80 mg/dl and student is conscious and able to swallow, please give the following amount of carbohydrates and recheck blood glucose in 15 minutes.**	☐ 10g	☐ 15g
• Repeat until blood glucose level is above 80 mg/dl		

If student is unconscious or having seizure give:	• **Baqsimi Intranasal**	☐ **3.0 mg**	
	• **Glucagon injection IM**	☐ **0.5 mg**	☐ **1.0 mg**
	• **HypoPen**	☐ **0.5mg**	☐ **1.0mg**

If Glucagon, Baqsimi, or HypoPen are indicated, administer it simultaneously while calling 911 and parents/guardians.

HYPERGLYCEMIA (High Blood Sugar)

Check ketones if blood glucose is 350 mg/dl or higher? ☐ Yes ☐ No

IF KETONES are MODERATE or LARGE, student will be sent home.
If ketone are trace or small and student is without symptoms, student may stay at school.

If Ketone supplies are not at school, the student is symptomatic, and remains over 350 for more than 1 hour, the student will be sent home.

Give insulin per doctor's orders (*if no correction dose was given within the previous 3 hours*): ☐ Yes ☐ No

Student's Level of independence:

Student can perform own blood glucose checks	☐ No	☐ With Supervision	☐ Yes
Student can calculate carbohydrates independently	☐ No	☐ With Supervision	☐ Yes
Student can determine correct amount of insulin	☐ No	☐ With Supervision	☐ Yes
Student can draw correct dose of insulin	☐ No	☐ With Supervision	☐ Yes
Student can give own injections	☐ No	☐ With Supervision	☐ Yes
Student can bolus correctly (for carbohydrates and for correction of hyperglycemia)	☐ No	☐ With Supervision	☐ Yes
Student can troubleshoot alarms and malfunctions on pump	☐ No	☐ Yes	
Student may carry own diabetic supplies (ie:pen/glucometer)	☐ No	☐ Yes	
Student needs cellphone, receiver, and/or pump, and other diabetes monitoring devices with them at all times	☐ No	☐ Yes	

Authorized Healthcare Provider Authorization for Management of Diabetes In School Setting

My signature below provides authorization for this Diabetes Medical Management Plan. I understand in some school districts specialized health care services may be observed by unlicensed designated school personnel under the training provided by a Credentialed School Nurse or Registered Nurse. **This authorization is for the current school year. If changes are indicated, I will provide new written authorization.**

MD/DO/PA Name: *(print)*		**Stamp:** (or address and phone)	
MD/DO/PA Signature:	**Date:**		
Physician's Telephone:		**Physician's NPI:**	
Medical Provider:	☐ Kaiser ☐ UCD Medical Center ☐ Sutter ☐ Other:_____		
Parent/Guardian Signature:		**Date:**	

My signature in this box authorizes the exchange of information on the above diagnosis pertaining to my child between designated Roseville City School District staff and my child's physician named above:

_____
Parent/Guardian Signature