American Diabetes Association.
Connected for Life

Safe at School®

Diabetes Medical Management Plan

(Add student photo here.)

SCHOOL YEAR:

STUDENT LAST NAME: FIRST NAME: DOB:

TABLE OF CONTENTS

PARENTS/GUARDIANS: Please complete pages 1 and 2 of this form and approve the final plan on page 6.

1. DEMOGRAPHIC INFORMATION—PARENT/GUARDIAN TO COMPLETE

Student First Name: Last Name: DOB: Student's Cell #: Diabetes Type: Date Diagnosed: Month: Year:

School Name: School Phone #: School Fax #: Grade:

Home Room: School Point of Contact: Contact Phone #:

STUDENT'S SCHEDULE Arrival Time: Dismissal Time:

Travels to school by (check all that apply):	Meals Times:	Physical Activity:	Travels to:
☐ Foot/Bicycle	☐ Breakfast	☐ Gym	☐ Home ☐ After School Program
☐ Car	☐ AM Snack	☐ Recess	Via: ☐ Foot/Bicycle
☐ Bus	☐ Lunch	☐ Sports	☐ Car
☐ Attends Before School Program	☐ PM Snack	☐ Additional information:	☐ Student Driver
	☐ Pre Dismissal Snack		☐ Bus

Parent/Guardian #1 (contact first): Relationship:

Cell #: Home #: Work #:

E-mail Address:

Indicate preferred contact method:

Parent/Guardian #2: Relationship:

Cell #: Home #: Work #:

E-mail Address:

Indicate preferred contact method:

2. NECESSARY SUPPLIES / DISASTER PLANNING / EXTENDED FIELD TRIPS

1. A 3-day minimum of the following Diabetes Management Supplies should be provided by the parent/guardian and accessible for the care of the student at all times.

- Insulin
- Syringe/Pen Needles
- Ketone Strips
- Treatment for lows and snacks
- Glucagon
- Antiseptic Wipes
- Blood Glucose (BG) Meter with (test strips, lancets, extra battery) – required for all Continuous Glucose Monitor (CGM) users
- Pump Supplies (Infusion Set, Cartridge, extra Battery/Charging Cord) if applicable
- Additional supplies:

2. View Disaster/Emergency Planning details – refer to Safe at School Guide

3. Please review expiration dates and quantities monthly and replace items prior to expiration dates

4. In the event of a disaster or extended field trip, a school nurse or other designated personnel will take student's diabetes supplies and medications to student's location.

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

3. SELF-MANAGEMENT SKILLS (DEFINITIONS BELOW)

		Full Support	Supervision	Self-Care
Glucose Monitoring:	Meter	☐	☐	☐
	CGM ☐(Requires Calibration)	☐	☐	☐
Carbohydrate Counting		☐	☐	☐
Insulin Administration:	Syringe	☐	☐	☐
	Pen	☐	☐	☐
	Pump	☐	☐	☐
Can Calculate Insulin Doses		☐	☐	☐
Glucose Management:	Low Glucose	☐	☐	☐
	High Glucose	☐	☐	☐

Self-Carry Diabetes Supplies: ☐ Yes ☐ No Please specify items:
Smart Phone: ☐ Yes ☐ No

Device Independence: ☐ CGM ☐ Interpretation & Alarm Management ☐ Sensor Insertion ☐ Calibration ☐ Insulin Pumps ☐ Bolus
☐ Connects/Disconnects ☐ Temp Basal Adjustment ☐ Interpretation & Alarm Management ☐ Site Insertion ☐ Cartridge Change

Full Support: All care performed by school nurse and trained staff (as permitted by state law).
Supervision: Trained staff to assist & supervise. Guide & encourage independence.
Self-Care: Manages diabetes independently. Support is provided upon request and as needed.

4. STUDENT RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CHECK ALL THAT APPLY)

Symptoms of High:
☐ Thirsty ☐ Frequent Urination ☐ Fatigued/Tired/Drowsy ☐ Headache ☐ Blurred Vision ☐ Warm/Dry/Flushed Skin
☐ Abdominal Discomfort ☐ Nausea/Vomiting ☐ Fruity Breath ☐ Unaware ☐ Other:

Symptoms of Low:
☐ None ☐ Hungry ☐ Shaky ☐ Pale ☐ Sweaty ☐ Tired/Sleepy ☐ Tearful/Crying ☐ Dizzy Irritable
☐ Unable to Concentrate ☐ Confusion ☐ Personality Changes ☐ Other:

Has student lost consciousness, experienced a seizure or required Glucagon: ☐ Yes ☐ No If yes, date of last event:
Has student been admitted for DKA after diagnosis: ☐ Yes ☐ No If yes, date of last event:

5. GLUCOSE MONITORING AT SCHOOL

Monitor Glucose:
☐ Before Meals ☐ With Physical Complaints/Illness (include ketone testing) ☐ High or Low Glucose Symptoms
☐ Before Exams ☐ Before Physical Activity ☐ After Physical Activity ☐ Before Leaving School ☐ Other:

CONTINUOUS GLUCOSE MONITORING (CGM)

(Specify Brand & Model:

Specify Viewing Equipment: ☐ Device Reader ☐ Smart Phone
☐ Insulin Pump ☐ Tablet or iPod ☐ Smart Watch

☐ CGM is remotely monitored by parent/guardian.
Document individualized communication plan in Section 504 or other plan to minimize interruptions for the student.
☐ May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

CGM Alarms:

Low alarm mg/dL

High alarm mg/dL if applicable

☐ **Section 1-5 completed by Parent/Guardian**

Please:
- Permit student access to viewing device at all times
- Permit access to School Wi-Fi for sensor data collection and data sharing
- Do not discard transmitter if sensor falls

Perform finger stick if:
- Glucose reading is below mg/dL or above mg/dL
- If CGM is still reading below mg/dL (DEFAULT 70 mg/dL) 15 minutes following low treatment
- CGM sensor is dislodged or sensor reading is unavailable, (see CGM addenda for more information)
- Sensor readings are inconsistent or in the presence of alerts/alarms
- Dexcom does not have both a number and arrow present
- Libre displays Check Blood Glucose Symbol
- Using Medtronic system with Guardian sensor

Notify parent/guardian if glucose is:

below mg/dL (<55 mg/dL DEFAULT)

above mg/dL (>300 mg/d DEFAULT)

Name of Health Care Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

6. INSULIN DOSES AT SCHOOL - HEALTHCARE PROVIDER TO COMPLETE

Insulin Administered Via:

☐ Syringe ☐ Insulin Pen (☐ Whole Units ☐ Half Units) ☐ Insulin Pump (Specify Brand & Model:)
☐ i-Port ☐ Smart Pen
☐ Other

☐ Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device
☐ Insulin Pump is using DIY Looping Technology (child/parent manages device independently, nurse will assist with all other diabetes management)

☐ **DOSING** to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 6A).

Insulin Administration Guidelines

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with students that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when student does not complete their meal.

☐ **Prior to Meal** (DEFAULT)
☐ **After Meal** as soon as possible and within 30 minutes
☐ **Snacking** avoid snacking hours (DEFAULT 2 hours) before and after meals

Partial Dose Prior to Meal: (preferred for unpredictable eating patterns using **insulin pump therapy**)

☐ Calculate meal dose using grams of carbohydrate prior to the meal
☐ Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)
☐ May advance to Prior to Meal when student demonstrates consistent eating patterns.

For Injections, Calculate Insulin Dose To The Nearest:

☐ Half Unit (round down for < 0.25 or < 0.75 and round up for ≥ 0.25 or ≥ 0.75)
☐ Whole Unit (round down for < 0.5 and round up for ≥ 0.5)

Supplemental Insulin Orders:

☐ Check for **KETONES** before administering insulin dose if BG > mg/dL (DEFAULT >300 mg/dL or >250 mg/dL on insulin pump) or if student complains of physical symptoms. Refer to section 9. for high blood glucose management information.

☐ Parents/guardians are authorized to adjust insulin dose +/- units

- ☐ Insulin dose +/- units
- ☐ Insulin dose +/- %
- ☐ Insulin to Carb Ratio +/- grams/units
- ☐ Insulin Factor +/- mg/dL/unit

Additional guidance on parent adjustments:

Name of Health Care Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

American Diabetes Association. Connected for Life | Safe at School | **Diabetes Medical Management Plan**

STUDENT LAST NAME: FIRST NAME: DOB:

6A. DOSING TABLE—HEALTHCARE PROVIDER TO COMPLETE – SINGLE PAGE UPDATE ORDER FORM

Insulin: (administered for food and/or correction)

Rapid Acting Insulin: ☐ Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) ☐ Other:

Ultra Rapid Acting Insulin: ☐ Fiasp (Aspart) ☐ Lyumjev (Lispro-aabc) ☐ Other:

Other insulin: ☐ Humulin R ☐ Novolin R

Meal & Times	Food Dose		Glucose Correction Dose ☐ Use Formula ☐ See Sliding Scale 6B	☐ PE/Activity Day Dose
Select if dosing is required for meal	☐ **Carbohydrate Ratio:** Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	☐ **Fixed Meal Dose**	**Formula:** (Pre-Meal Glucose Reading minus **Target Glucose**) divided by **Correction Factor** = Correction Dose ☐ May give Correction dose every hours as needed (DEFAULT 3 hours)	**Adjust:** ☐ **Carbohydrate Dose** ☐ **Total Dose** Indicate dose instructions below:
☐ **Breakfast**	Breakfast Carb Ratio = g/unit	**Breakfast** units	☐ **Target Glucose** is: mg/dL & **Correction Factor** is: mg/dL/unit ☐ **No Correction dose**	Carb Ratio g/unit Subtract % Subtract units
☐ **AM Snack**	AM Snack Carb Ratio = g/unit ☐ No Carb Dose ☐ No Insulin if < grams	**AM Snack** units	☐ **Target Glucose** is: mg/dL & **Correction Factor** is: mg/dL/unit ☐ **No Correction dose**	Carb Ratio g/unit Subtract % Subtract units
☐ **Lunch**	Lunch Carb Ratio = g/unit	**Lunch** units	☐ **Target Glucose** is: mg/dL & **Correction Factor** is: mg/dL/unit ☐ **No Correction dose**	Carb Ratio g/unit Subtract % Subtract units
☐ **PM Snack**	PM Snack Carb Ratio = g/unit ☐ No Carb Dose ☐ No Insulin if < grams	**PM Snack** units	☐ **Target Glucose** is: mg/dL & **Correction Factor** is: mg/dL/unit ☐ **No Correction dose**	Carb Ratio g/unit Subtract % Subtract units
☐ **Dinner**	Dinner Carb Ratio = g/unit	**Dinner** units	☐ **Target Glucose** is: mg/dL & **Correction Factor** is: mg/dL/unit ☐ **No Correction dose**	Carb Ratio g/unit Subtract % Subtract units

6B. CORRECTION SLIDING SCALE

☐ Meals Only ☐ Meals and Snacks ☐ Every hours as needed

to mg/dL = units	to mg/dL = units	to mg/dL = units
to mg/dL = units	to mg/dL = units	to mg/dL = units
to mg/dL = units	to mg/dL = units	to mg/dL = units

6C. LONG ACTING INSULIN

Time	☐ Lantus, Basaglar, Toujeo (Glargine) ☐ Levemir (Detemir) ☐ Tresiba (Degludec) ☐ Other	units	☐ Daily Dose ☐ Overnight Field Trip Dose ☐ Disaster/Emergency Dose	Subcutaneously

6D. OTHER MEDICATIONS

Time	☐ Metformin ☐ Other	units	☐ Daily Dose ☐ Overnight Field Trip Dose ☐ Disaster/Emergency Dose	Route

Signature is required here if sending ONLY this one-page dosing update.

Diabetes Provider Signature: **Date:**

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

7. LOW GLUCOSE PREVENTION (HYPOGLYCEMIA)

Allow Early Interventions

☐ Allow Mini-Dosing of carbohydrate (i.e.,1-2 glucose tablets) when low glucose is predicted, sensor readings are dropping (down arrow) at mg/dL (DEFAULT 80 mg/dL or 120 mg/dL prior to exercise) or with symptoms.

☐ Allow student to carry and consume snacks ☐ School staff to administer

☐ Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (DEFAULT)

Insulin Management (Insulin Pumps)

Temporary Basal Rate Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia.

☐ Pre-programmed Temporary Basal Rate Named (OmniPod)

☐ Temp Target (Medtronic) ☐ Exercise Activity Setting (Tandem)

Start: minutes prior to exercise for minutes duration (DEFAULT 1 hour prior, during, and 2 hours following exercise).

Initiated by: ☐ Student ☐ Trained School Staff ☐ School Nurse

☐ May disconnect and suspend insulin pump up to minutes (DEFAULT 60 minutes) to avoid hypoglycemia, personal injury with certain physical activities or damage to the device (keep in a cool and clean location away from direct sunlight).

Exercise (Exercise is a very important part of diabetes management and should always be encouraged and facilitated).

Exercise Glucose Monitoring

☐ prior to exercise ☐ every 30 minutes during extended exercise ☐ following exercise ☐ with symptoms

Delay exercise if glucose is < mg/dL (120 mg/dL DEFAULT)

Pre-Exercise Routine

☐ **Fixed Snack:** Provide grams of carbohydrate prior to physical activity if glucose < mg/dL

☐ **Added Carbs:** If glucose is < mg/dL (120 DEFAULT) give grams of carbohydrates (15 DEFAULT)

☐ **TEMPORARY BASAL RATE as indicated above**

Encourage and provide access to water for hydration, carbohydrates to treat/prevent hypoglycemia, and bathroom privileges during physical activity

8. LOW GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Low Glucose below mg/dL (below 70 mg/dL DEFAULT) or below mg/dL before/during exercise (DEFAULT is < 120 mg/dl).

1. If student is awake and able to swallow give grams of fast acting carbohydrate (DEFAULT 15 grams). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.
   ☐ School nurse/parent may change amount given
2. Check blood glucose every 15 minutes and re-treat until glucose > mg/dL (DEFAULT is 80 mg/dL or 120 mg/dL before exercise).

SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)
Administer Glucagon, position student on their side and monitor for vomiting, call 911 and notify parent/guardian. If BG meter is available, confirm hypoglycemia via BG fingerstick. Do not delay treatment if meter is not immediately available. If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with student.

☐ Glucagon Emergency Kit by IM injection ☐ Gvoke by SC injection ☐ Auto-Injection, Gvoke HypoPen
Dose: ☐ 0.5 mg or ☐ 1.0 mg

☐ Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector ☐ Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe

☐ Baqsimi Nasal Glucagon 3 mg

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

9. HIGH GLUCOSE MANAGEMENT (HYPERGLYCEMIA)

Management of High Glucose over mg/dL (Default is 300 mg/dL OR 250 mg/dl if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 30 minutes. May consume fluids in classroom. Allow frequent bathroom privileges.
2. Check for Ketones (before giving insulin correction)
   a. If Trace or Small Urine Ketones (0.1 – 0.5 mmol/L if measured in blood)
      - Consider insulin correction dose. Refer to the "Correction Dose" Section 6.A-B. for designated times correction insulin may be given.
      - *Can return to class and PE unless symptomatic*
      - Recheck glucose and ketones in 2 hours
   b. If Moderate or Large Urine Ketones (0.6 – 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.
      - Contact parents/guardian or, if unavailable, healthcare provider
      - **Administer correction dose via injection.** If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the "Blood Glucose Correction Dose" Section 6.A-B
      - If using insulin pump change infusion site/cartridge or use injections until dismissal.
      - No physical activity until ketones have cleared
      - Report nausea, vomiting, and abdominal pain to parent/guardian to take student home.
      - Call 911 if changes in mental status and labored breathing are present and notify parents/guardians.

☐ Send student's diabetes log to Health Care Provider (include details): If pre-meal blood glucose is below 70 mg/dL or above 240 mg/dL more than 3 times per week or you have any other concerns.

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider: Date:

I, (parent/guardian) give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to collaborate with my child's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian: Date:

Acknowledged and received by:

School Nurse or Designee: Date:

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

Dr. Robert J. Underwood
Superintendent

Indian Lake Schools

6210 SR 235 North
Lewistown, Ohio 43333
937-686-8601 · Fax: 937-686-8421

Coleen Reprogle
Treasurer

March 2022

Students with any medication to be stored or given at school such as daily, emergency or as needed, must provide the appropriate updated Medication Administration form **each school year**. There is a form for prescription medications that doctors sign and a different form for over the counter medications that parents simply sign when they drop off the medication for school.

Please note that Medication Administration Forms are also required for medications that students self-carry. Ohio law only lists 3 self-carry medications for school which include inhalers, epinephrine auto injector and glucagon. **ORC 3313.718** also states that in order for students to self-carry epinephrine auto injector, a second backup is to be received by the school. There is an area on the administration form for both the doctor and parent to sign consent for the student to self-carry these medications.

Remember students are not permitted to transport medications to/from school. A parent or guardian signature is necessary for medication to be signed in/out of clinic inventory. Finally, all medication **MUST** be stored in the original container with the label matching the signed doctor's order.
For questions please contact District Nurse, Kourtney Thompson at 937-686-7323.

Sincerely,

Robert J. Underwood
Superintendent

Indian Lake Elementary School
8779 CR 91
Lewistown, Ohio 43333
Phone: 937-686-7323
Fax: 937-686-0049
Molly Hall, Principal
Pamela Scarpella, Asst. Principal

Indian Lake Middle School
8920 CR 91
Lewistown, Ohio 43333
Phone: 937-686-8833
Fax: 937-686-8993
Melissa Mefford, Co-Principal, Operations
Erin Miller, Co-Principal, Instruction

Indian Lake High School
6210 SR 235 North
Lewistown, Ohio 43333
Phone: 937-686-8851
Fax: 937-686-0024
Kyle Wagner, Principal
David Coburn, Asst. Principal

Indian Lake Local Schools
Medication Administration Form
(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name				Date of birth
Student address				
School	Grade/Class	Teacher		School year
List any known drug allergies/reactions			Height	Weight

Prescriber Authorization

Name of medication	Circumstance for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	
Circumstances for use		
Special instructions		
Treatment in the event of an adverse reaction		
Epinephrine Autoinjector ❑ Not applicable ❑ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.		
Asthma Inhaler ❑ Not applicable ❑ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.		
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief		
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718 a) To the student for whom it is prescribed (that should be reported to the prescriber) b) To a student for whom it is not prescribed who receives a dose		
Other medication instructions Does medication require refrigeration? ❑ Yes ❑ No Is the medication a controlled substance? ❑ Yes ❑ No		
Prescriber signature	Date	Phone / Fax
Prescriber name (print) Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.		

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

❑ *For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

❑ *For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

HEA 7758 5/11

Please fax form to IL School Nurse Kourtney Thompson at 937-686-0049

❑ File per district policy