LOS ANGELES UNIFIED SCHOOL DISTRICT
Medical Services Division
District Nursing Services Branch

Diabetes Medical Management Plan for School & School-Sponsored Events
Individualized School Healthcare Plan (ISHP) will provide details for implementation.

Healthcare Provider Authorization and Parent Consent

Student:_____ DOB: _____ Gender: ☐ Male ☐ Female ☐ Non-binary

School:_____ Grade:_____ Diabetes Type:_____

1. **Student is capable of independent self-management (Ind), self-management with supervision (Sup), or total care (Total) for the following:**

Blood glucose testing-glucometer: BGM	☐ Independent	☐ Supervised	☐ Total Care
Continuous Glucose Monitor (CGM):	☐ Independent	☐ Supervised	☐ Total Care
Carbohydrate counting:	☐ Independent	☐ Supervised	☐ Total Care
Inject insulin with syringe:	☐ Independent	☐ Supervised	☐ Total Care
Inject insulin with pen:	☐ Independent	☐ Supervised	☐ Total Care
Deliver insulin with a pump:	☐ Independent	☐ Supervised	☐ Total Care

2. **Blood Glucose Monitoring:** Desired range _____ mg/dL
   - ☐ Before meals ☐ Before breakfast ☐ Before lunch ☐ Before snacks/recess/mid-am
   - ☐ For symptoms of high/low (feeling ill)
   - ☐ Before physical activity
   - ☐ Before end-of-school ☐ Before after-school-program
   - ☐ Other times: _____

   CGM: Brand/Model:_____ Alert setting: low;_____ high _____
   - ☐ Ok to use CGM to dose insulin.

   Confirm CGM with finger stick if:
   - ☐ CGM alert for hypo/hyperglycemia
   - ☐ CGM sensor glucose (SG) reading does not match the student's symptoms
   - ☐ There is no sensor glucose value or trend arrow direction present
   - ☐ The child is symptomatic
   - ☐ There are 2 arrows (up & down)
   - ☐ When in doubt of CGM accuracy
   - ☐ Finger stick prior to any correction for elevated glucose level at _____ mg/dL

3. **Care of Hypoglycemia (treatment of low blood glucose). *Student must never be alone when hypoglycemia is suspected and need continuous adult supervision & assistance*.**

   Treatment for glucose level: <_____ mg/dL. Give:_____ grams of quick-acting carbohydrates

   Treat with one of the following**:** juice or regular soda_____ oz; glucose tab(s)_____tab(s); glucose gel _____tube; hard candy_____pcs; sugar or honey_____ Tbsp; others: _____

   Recheck glucose level in 15 minutes. *Repeat treatment if glucose level is still < _____mg/dL

   NOTE: If still hypoglycemic after 3 treatments: CALL PARENTS

   If lunch or snack is more than an hour away, post-hypoglycemia treatment, give _____ g. complex CHO without insulin.

Emergency Care for Severe Hypoglycemia.
- ☐ Symptoms: seizure, loss of consciousness, and unable to swallow.
- ☐ Glucagon IM/SQ _____mg into the arm/thigh. Call 911 if used.

- ☐ Glucagon Auto injection SQ (Gvoke) _____ mg into the upper arm or thigh. Call 911 if used.
- ☐ Glucagon NAS (Baqsimi) 3mg (one spray) into one nostril. Call 911 if used.

4. **Care of Hyperglycemia (Treatment of high blood glucose)**
   - ☐ Do not give correction dose more frequently than every _____ hours since the last insulin dose
   - ☐ Intervene if BG is > _____ mg/dL with symptoms and provide extra water
   - ☐ Check urine ketones if feeling ill &/or blood glucose > _____ mg/dL
   - ☐ For ketone moderate-large, give correction dose plus extra _____ units of rapid-acting insulin
   - ☐ Notify parent if BG > _____ or if ketones med-large or symptomatic (nausea, vomiting and abdominal pain) for pick up.
   - ☐ For asymptomatic without or with trace-small ketone - send back to class.
   - ☐ Call 911 for labored breathing, confusion, or unconsciousness.
5. **Exercise/Sport Guidelines**
   - ☐ Fast-acting carbs should always be readily available for hypoglycemia.
   - ☐ If BG is more than or equal to _____ mg/dL prior to PE, with steady or rising arrow on CGM, hold the _____ g snack.
   - ☐ Before PE: If BG is less than _____ mg/dL, give _____ g of CHO without insulin
   - ☐ Students may participate in sports: ☐ Yes ☐ No
   - ☐ No exercise for positive urine ketones
   - ☐ No exercise for blood glucose > _____ mg/dL; or if blood glucose < _____ mg/dL.

INSULIN THERAPY:

Insulin Type: _____

Insulin Administration via: ☐ Syringe ☐ Insulin pen ☐ In-pen ☐ Insulin pump

INSULIN CORRECTION FREQUENCY:

- ☐ Before Breakfast ☐ Before AM snack ☐ Before Lunch ☐ Before end of school
- ☐ Before PM snack ☐ other: _____

Insulin correction can ONLY be given _____ hours from the last insulin dose

CARBOHYDRATE COVERAGE:

- ☐ Before Breakfast ☐ Before AM snack ☐ Before Lunch ☐ Before end of school
- ☐ Before PM snack ☐ other: _____
- ☐ Carbohydrate coverage for all CHO eaten
- ☐ Do not cover snack/meal if carbs to be eaten is < _____ g

Carbohydrate Coverage Dose determined by:

- ☐ I:C Ratio _____ unit(s) insulin per _____ g CHO
- ☐ Fixed Dose (meal) _____ unit(s) insulin up to _____ g CHO
- ☐ Fixed Dose (snack) _____ unit(s) insulin up to _____ g CHO

Insulin Correction Dose: _____ unit(s) for every _____ mg/dL over _____ mg/dL

Correction Dosage Sliding Scale:

Blood Glucose _____ to _____ = _____ units
Blood Glucose _____ to _____ = _____ units
Blood Glucose _____ to _____ = _____ units
Blood Glucose _____ to _____ = _____ units
Blood Glucose _____ to _____ = _____ units
Blood Glucose _____ to _____ = _____ units
Blood Glucose _____ to _____ = _____ units

Student: _____ DOB: _____

PUMP REGIMEN:

Time:	Basal Rate:	I:CR	Sens Factor:	Target:

DOSING to be determined by Bolus Calculator in insulin pump

Insulin Pumps- Type & model: _____

In the event of insulin pump site or mechanical failure:

- ☐ If BG is **>** _____ mg/dL and ketones are moderate to large, encourage drinking water and call the parent or guardian to disconnect and replace the pump. Once disconnected, give the insulin correction/coverage bolus using an insulin syringe or pen.
- ☐ If the parent/guardian cannot be reached, notify the student's healthcare provider and Region Nursing Services immediately regarding signs of possible pump malfunction. Discontinue insulin delivery via the pump as a precaution. Then follow the manufacturer's instructions to either power off the pump or deactivate the pod.
- ☐ After turning off the pump or deactivating the pod, administer the recommended insulin dose for correction and carbohydrate coverage using an insulin syringe or pen.
- ☐ If **>**2 hours remaining in the school day, the student should either have a new pump site placed by the parent or parent designee, or they should continue to receive insulin for correction every two hours if hyperglycemic.
- ☐ Other instructions: _____

_____

_____

6. **Disaster Plan:**

• Inject long-acting insulin: _____ u SQ @ _____ am/pm

• Check BG every _____ hour(s) & follow the dosing instructions above for correction and coverage.

• For students on an insulin pump, maintain basal rates as programmed with meals and correction boluses as needed.

****NOTE: Parents/guardians are not allowed to verbally or in written form change orders with the school nurse, nor can they give orders to their child unless they are independent in all diabetes competencies. If parents/guardians want to dose other than the orders above, they need to go to the school to administer the insulin or ask the provider to re-fax new orders for the parents/guardians to provide written consent.***

CALCULATION FORMULA:

- **CHO Coverage Dose:** grams of CHO in meal **÷** grams of CHO in I:CR **=** Total Insulin coverage dose
- **Correction Dose:** BG **–** target **÷** Correction Factor or Insulin Sensitivity Factor (ISF) **=** Total Insulin correction dose.
- **Rounding Rule:**
  - **Half unit rounding:** 0.01-0.24 round down, 0.25-0.74 round to 0.5. 0.75-0.99 round-up.
  - **Whole unit rounding:** 0.0-49 round down, 0.50-0.99 round up.

Student: _____ DOB: _____

Authorized Health Care Provider Authorization for Management of Diabetes at School

My signature below provides authorization for the above written order, including administration of diabetes medications such as insulin, non-insulin injectables, oral medications, and glucagon products. I understand that all procedures will be implemented in accordance with state laws and regulations.

I understand that specialized physical health care services may be performed by unlicensed designated school staff.

Authorized Healthcare Provider Name/Title: _____ Signature: _____ Date: _____

Phone: _____ Address: _____ City: _____ Zip: _____

Furnishing Number: *Nurse Practitioner, Nurse Midwife, Physician Assistant: _____

Parent Consent for Management of Diabetes at School

I give permission to the licensed nurse and other designated staff members to perform and carry out the diabetes care tasks outlined in this form in accordance with Education Code Section 49423.5. I also consent to the release of the information contained in this plan to all staff members and other adults who have custodial care of my child who may need to know this information to maintain my child's health and safety.

1. Provide the necessary supplies and equipment.

2. Notify the school nurse if there is a change in pupil health status or attending Healthcare Provider.

3. Notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

4. Provide new written consent/authorization yearly.

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Consentimiento de los padres para el control de la diabetes en la escuela Le otorgo permiso a la enfermera con licencia y a otros miembros del personal designados para realizar y llevar a cabo las tareas de cuidado de la diabetes descritas en este formulario de acuerdo con la Sección 49423.5 del Código de Educación. También doy mi consentimiento para que se divulgue la información contenida en este plan a todos los miembros del personal y a otros adultos que estén al cuidado de mi hijo y que puedan necesitar esta información para mantener la salud y seguridad de mi hijo.

1. Proporcionar los insumos y equipos necesarios.

2. Notificar a la enfermera de la escuela si hay un cambio en el estado de salud del estudiante o en el prestador de servicios médicos que lo atiende.

3. Notificar inmediatamente a la enfermera de la escuela y proporcionar un nuevo consentimiento/autorización por escrito para cualquier cambio en la autorización anterior.

4. Proporcionar anualmente un nuevo consentimiento/autorización por escrito.

Yo otorgo mi (nosotros otorgamos nuestro) consentimiento para que la enfermera de la escuela se comunique con el prestador de servicios médicos autorizado cuando sea necesario.

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

(Nombre del Padre de Familia/Guardian) *(Firma)* *(Fecha)*

Home phone: _____ **Work phone:** _____ **Cell phone:** _____

(Telefono de casa) *(Telefono del trabajo)* *(Telefono movil)*

Licensed Nurse Acknowledgement, Reviewed per District Guideline

Printed Name of Nurse	**Signature**	**Title (RN/LVN)**	**Date**
_____	_____	_____	_____