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 (*Select One): ☐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)	☐ 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
☐ Inject insulin with pump	☐ Independent	☐ Supervised	☐ Total Care

2. **Blood Glucose Monitoring:** Desired range _____mg/dL
   ☐ Before meals ☐ Before snacks/recess/mid-am
   ☐ For symptoms of high/low (feeling ill)
   ☐ Before physical activity (> ___ min.)
   ☐ Before end of school ☐ 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) levels which is not the same as the blood glucose (BG)or there is no sensor glucose value.
   ☐ The child is symptomatic
   ☐ There are 2 arrows (up & down)
   ☐ When in doubt
   ☐ **Finger stick prior to any correction for elevated BG at _____**
3. **Care of Hypoglycemia (Treatment of low blood glucose)** *Student must never be alone when hypoglycemia is suspected and needs continuous adult supervision & assistance.*
   Treatment for blood glucose <____ mg/dL.
   Treat with one of the following _____ g/CHO: _____ juice or regular soda, _____ glucose tabs, ____ glucose gel, _____ hard candy, _____ sugar, or _____ honey
   Recheck blood glucose in 15 minutes ●Repeat treatment if blood glucose <___ 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____ gm 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 or 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.
   ☐ Intervene if BG is >_____ mg/dL with symptoms and provide extra water
   ☐ Insulin correction can be given as often as ___ hrs. since the last insulin dose
   ☐ 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
   Student may participate in sports ☐ Yes ☐ No
   No exercise for positive urine ketones and/or blood glucose >_____ mg/dL; or if blood glucose <_____ mg/dL.

INSULIN THERAPY:
Insulin Type: _____
Insulin Administration via ☐ syringe ☐ pen ☐ in-pen ☐ pump
WHEN TO GIVE INSULIN CORRECTION:
☐ Before Breakfast ☐ Before AM snack ☐ Before Lunch
☐ Before PM snack ☐ Before end of school ☐ other: _____
Insulin correction can ONLY be given _____ hours from the last insulin dose
CARBOHYDRATE COVERAGE:
☐ Before Breakfast ☐ Before AM snack ☐ Before lunch
☐ Before pm snack ☐ Before end of school
☐ Carbohydrate coverage for all CHO eaten
☐ No coverage for snack/meal if < _____g
☐ Other: _____

INSULIN BOLUS DOSE DETERMINED BY:
Carbohydrate Coverage Dose
I:C Ratio ___unit(s) insulin per ____g CHO
Fixed Dose (lunch) ___ 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 starting at _____mg/dL
Correction Dosage 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
Blood Glucose _____	to _____	= _____	units
Blood Glucose 550+ or "Hi"		= _____	units

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 the pump.
Once disconnected, give a correction dose of insulin using an insulin syringe or pen.
● If the parents cannot be reached, call the healthcare provider, stop insulin, and turn off the pump by following the manufacturer's manual.
● After turning off the pump, administer the recommended insulin dose for correction or 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.

6. **Disaster Plan:**
- Inject long-acting insulin: _____ _____ u SQ @ _____
- Check BG every ____ hour(s) & follow dosing instructions above for correction and coverage.
- For students on insulin pump, maintain basal rates as programmed with meal 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 ***divided by*** grams of CHO in I:CR **=** Total Insulin coverage dose
- **Correction Dose:** BG ***minus*** target ***divided by*** Correction Factor or Insulin Sensitivity Factor (ISF) ***multiply by*** correction dose (if correction dose is an increment **other than 1 unit; skip this step if given value is 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.

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: _____

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

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 Guidelines

Printed Name of Nurse	Signature	Title (RN/LVN	Date