



DIABETES MEDICAL MANAGEMENT PLAN FOR THE STUDENT WITH DIABETES ON INSULIN PUMP

Student:		DOB:	School:	Grade:
Address:			Home Phone:	
Notification to Parents:	Low Blood Glucose - less than _____ mg/dL	High Blood Glucose - greater than _____ mg/dL		
Continuous glucose monitoring: See Continuous Monitoring Orders <input type="checkbox"/>				
Hypoglycemia Mild/Moderate Treatment: <input type="checkbox"/> less than 70 mg/dL <input type="checkbox"/> less than _____ mg/dL Follow <i>Rule of 15</i> : Treat with <input type="checkbox"/> 2-4 Glucose Tabs <input type="checkbox"/> 4 ounces juice <input type="checkbox"/> Glucose gel (use finger, place between cheek & gum in mouth) <input type="checkbox"/> If no meal or snack within the next hour, give a 15 gram snack IMPORTANT: Always RECHECK blood glucose in 15 minutes & repeat above if needed and NOTIFY PARENT/GUARDIAN IF blood glucose LESS THAN _____ mg/dL				
Hypoglycemia: Severe Symptoms with loss of consciousness/seizures: Call 911 and administer emergency medication Glucagon <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg IM, Arm or Thigh Gvoke <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg Subcutaneous, Arm or Thigh Zegalouge <input type="checkbox"/> 0.6 mg Subcutaneous, Arm or Thigh Baqsimi <input type="checkbox"/> 3 mg Intranasal				
Hyperglycemia Treatment:		If Blood Glucose is greater than 250 mg/dL twice in a row:		
<input checked="" type="checkbox"/> Provide water/ access to bathroom		<input checked="" type="checkbox"/> Test urine ketones; call parent/guardian if ketones moderate to large		<input checked="" type="checkbox"/> See below for insulin instructions if applicable
IMPORTANT: Student should not be sent home from school with elevated blood glucose UNLESS student is too ill to participate in school activities and/or has moderate ketones and vomiting present.				
When to Check Blood Glucose: <input checked="" type="checkbox"/> Always for signs and symptoms of low/high blood glucose, when not feeling well, and/or behavior concerns.				
<input type="checkbox"/> Before breakfast	Before Activity: <input type="checkbox"/> Gym / <input type="checkbox"/> Recess		Blood Glucose/Sensor Glucose should be greater than _____ mg/dL	
<input type="checkbox"/> Before lunch	Before Dismissal: <input type="checkbox"/> Walking home / <input type="checkbox"/> Riding bus		Blood Glucose/Sensor Glucose should be greater than _____ mg/dL	
<input type="checkbox"/> Before snacks	**See continuous glucose monitoring (CGM) orders if applicable**			
INSULIN PUMP - Insulin Pump Brand: <input type="checkbox"/> Medtronic <input type="checkbox"/> OmniPod <input type="checkbox"/> Tandem				
Insulin: <input type="checkbox"/> Apidra / Humalog(Lispro) / Novolog (Aspart) / Admelog / Fiasp				
<ul style="list-style-type: none"> • Pump settings are established by the student's Health Care Provider and should not be changed by the school staff. • All setting changes to be made at home or by student providing a level of self-care as indicated on Diabetes Medical Management Plan/504 Plan 				
When hyperglycemia occurs other than at lunchtime:				
<input type="checkbox"/> If it has been greater than _____ hours since the last bolus of insulin, the student may be given a bolus using the pump calculator instructions				
<input type="checkbox"/> All Correction Insulin and Carbohydrates Insulin Dosage Per Pump: <input type="checkbox"/> Breakfast <input type="checkbox"/> Snack <input type="checkbox"/> Lunch				
Bolus for carbohydrates should occur: <input type="checkbox"/> Immediately prior to meal <input type="checkbox"/> Immediately after breakfast/lunch <input type="checkbox"/> Other _____				
PUMP FAILURE: IN THE EVENT OF A PUMP/PUMP SITE FAILURE, DISCONNECT THE PUMP AND CONTACT THE PARENT.				
-If pump calculator IS operational, Insulin dosing can be calculated by using the pump bolus calculator and then insulin (carbohydrate coverage/glucose correction) given by INJECTION.				
-If pump calculator is NOT operational, then CALL THE PARENT for insulin dose to be given by INJECTION.				
-If the pump cannot be restarted/pump site replaced/the pump is not infusing Insulin, glucose levels should be checked every 3 hours with correction given by INJECTION for elevated glucose values				
Student's Care:				
	Nurse/Trained Staff	Student and Staff Together	Student Independent	
Glucose monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Carbohydrate counting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insulin dose calculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insulin administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Student may carry insulin with them <input type="checkbox"/> Student may carry diabetes monitoring supplies <input type="checkbox"/> Student may carry treatment for hypoglycemia				
<input type="checkbox"/> Student can change pump site as indicated on Diabetes Medical Management Plan/504 Plan				
Additional Information: Refer to student's 504 Plan for student specific accommodations.				
If your school has a metal detector or body scanner contact manufacturer for guidance.				
Printed Name of Provider		Signature of Provider		Date Time
To be completed by parent/guardian: I give permission for my child to receive medication at school according to the school district policy and as instructed by the Health Care Provider and agree to: <ul style="list-style-type: none"> • Assume responsibility for safe delivery of the medication in its original container to the school. • Notify the school immediately if there is any change in the use of this medication. • Notify the school of changes in Health Care Provider. • Allow designated school staff to send and/or receive information related to my child's health as they deem appropriate. • This form is valid for one year from the date signed by Health Care Provider. 				
Printed Name of Parent/Guardian		Signature of Parent/Guardian		Date Time





DIABETES MEDICAL MANAGEMENT PLAN FOR THE STUDENT WITH DIABETES ON CONTINUOUS GLUCOSE MONITOR

Fax to School Family to Pick up

Student:	DOB:	School:	Grade:
Address:		Home Phone:	

What is a CGM?

A Continuous Glucose Monitor (CGM) reads glucose levels from a sensor the interstitial fluid (under the skin). It usually reads within 20% of a finger stick blood sugar value. It can be programmed to alert (vibrate or alarm) for high and low glucose levels. The Dexcom G5, Dexcom G6 and Freestyle Libre are FDA approved as a replacement to finger sticks for use in making diabetes treatment decisions including dosing. A finger stick blood glucose value is required for calibration or if symptoms don't match sensor glucose reading. **Student should not dose off of a CGM value unless both a blood glucose reading and trending arrow are present.**

CGMs contain three parts: 1) **Glucose sensor:** Placed just under skin by the user. The sensor contains an electrode that detects changes in glucose levels. 2) **Transmitter:** Connects to the sensor and sends results to the receiver. 3) **Receiver:** Shows the glucose result and allows operation of the CGM. Receiver may be within a pump, phone, or electronic device. Most CGMs have software, which allows the user to track trends and communicate data to parent(s)/guardian/healthcare providers.

Alert Settings: A CGM may alert audibly if interstitial glucose is outside the parameters set by parent(s)/guardian.

Arrows: Arrows on the screen indicate the speed at which the glucose levels are changing.



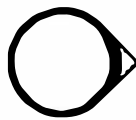
Glucose is rapidly rising.
May increase 90 mg/dl in 30 minutes



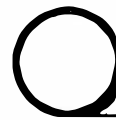
Glucose is rising.
May increase 60-90 mg/dL in 30 minutes



Glucose is slowly rising.
May increase 30-60 mg/dL in 30 minutes



Glucose is steady



Glucose is slowly decreasing.
May decrease 30-60 mg/dL in 30 minutes



Glucose is decreasing.
May decrease 60-90 mg/dL in 30 minutes



Glucose is rapidly decreasing.
May decrease 90 mg/dL in 30 minutes

Use of a CGM at School

When to check a finger stick blood glucose:

- When the sensor values is less than _____ or greater than _____
- If a trend arrow or sensor glucose is absent. (Both a trend arrow and glucose reading are necessary)
- If symptoms do not match presentation
- During sensor warm up period
- If device indicates a blood glucose check is required

Notify Parent/Guardian:

- Glucose Sensor becomes dislodged (*If transmitter falls off do not throw away! Give to family*)
- Soreness, redness or bleeding at site
- CGM Malfunction

Additional information:

- An individualized treatment plan in response to trend arrows will be developed between the school and the parent(s)/guardian.
- Parent(s)/guardian will ensure calibration of CGM daily per manufacturing recommendations
- CGM reading can be used for Pre-activity Dismissal from school Pre-meal glucose Snack glucose Other
- If your school has a metal detector or body scanner contact manufacturer for guidance

To be completed by parent/guardian: I give permission for my child to receive medication at school according to the school district policy and as instructed by the Health Care Provider and agree to:

- Assume responsibility for safe delivery of the medication in its original container to the school
- Notify the school immediately if there is any change in the use of this medication
- Notify the school of changes in Health Care Provider
- Allow designated school staff to send and/or receive information related to my child's health as they deem appropriate.
- This form is valid for one year from the date signed by Health Care Provider.

Parent/Guardian:	Date:
Provider:	Date:



Mail forms:
ATTN Endocrinology, Akron Children's Hospital
One Perkins Square
Akron OH 44308



Please PRINT and fill out entirely.

MRN
Facility Use Only

Form sections: Patient Information, Release TO, Release FROM, Purpose, Information to Release, Patient/Parent/Legal Guardian. Includes fields for name, address, phone, and checkboxes for release options.



HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS (FROM Children's)

MRN
_____ Facility Use Only

Please PRINT and fill out entirely.

Patient Information	Patient Name: _____ / ____ / ____ <small style="display: flex; justify-content: space-between; width: 100%;"> Last First Middle (any previous name) Date of Birth </small> Patient Street Address _____ City _____ State _____ Zip _____ Phone _____ (____) _____ (____) _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Phone Fax Email Address </small>			
Release To	Release Information TO the following Person(s) or Organizations: Name/Organization: _____ /School Attention: _____ Address _____ City _____ State _____ Zip _____ (____) _____ (____) _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Phone Fax Email Address </small>			
Purpose	Person/Place requesting records (check all that apply): <input checked="" type="checkbox"/> Patient/Parent/Legal Guardian <input type="checkbox"/> Doctor/Hospital <input type="checkbox"/> Lawyer <input type="checkbox"/> Insurance Company <input type="checkbox"/> Other _____ Purpose of Release (check all that apply): <input checked="" type="checkbox"/> Patient Care <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input checked="" type="checkbox"/> School <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use <input type="checkbox"/> Other _____			
Method of Release	Format of records to be released: <input checked="" type="checkbox"/> on paper <input checked="" type="checkbox"/> PDF [on CD or Jump Drive (if available)] <input checked="" type="checkbox"/> Verbal communication only with person or agency listed above Information May Be Sent Via: <i>(Note: Radiology images can only be placed on CD and mailed or picked-up)</i> <input checked="" type="checkbox"/> Mail Delivery <input checked="" type="checkbox"/> Fax <input checked="" type="checkbox"/> Pick Up <input checked="" type="checkbox"/> Encrypted Email* <input checked="" type="checkbox"/> to MyChart* (*electronic records only, size restrictions apply)			
Information to Release	Dates of Treatment Requested: _____ (If not specified, the LAST 6 MONTHS will be released) <input checked="" type="checkbox"/> Medical Record Abstract – pertinent information generally used for continued care/personal use/disability. The following items are included in a Medical Record Abstract: After Visit/Discharge Summary, Emergency Record History & Physical, Inpatient Consult Report(s) Operative Report(s), Radiology Reports, Lab or Other Tests <input type="checkbox"/> Other Information Requested (choose any to release): <input type="checkbox"/> Vaccination (shot) records <input type="checkbox"/> Billing Records <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Appointment list <input type="checkbox"/> Radiology Images on disc <input checked="" type="checkbox"/> Demographics page <input type="checkbox"/> Lab results (blood work) <input type="checkbox"/> Pathology Report <input type="checkbox"/> ACHP Records (specify ACHP): _____ <input checked="" type="checkbox"/> Doctor's Office Reports (Doctor or Department Name) _____ Center for Diabetes & Endocrinology <input checked="" type="checkbox"/> Other: (please list exact documents) AVS, School Form, Current Orders _____			
Patient/Parent/Legal Guardian	This authorization expires one year from the date of signature, OR on this date / event: _____ I understand that treatment does not depend on me signing this Authorization. I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else, except as prohibited by 42 CFR Part 2 or other applicable law. I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing, at Akron Children's Hospital, One Perkins Square, Akron, OH 44308. By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive the patient's health information. Signature of Patient or Parent/Legal Guardian _____ Printed Name _____ Date _____ My relationship to the patient is <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian – Attach <u>Court Order</u> to show your authority to sign Signature of Witness _____ Printed Name _____ Date _____			
Submit	Submit completed form AND a copy of a valid Photo ID (if a current one is not on file with us) to: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">Mail form to: Akron Children's Hospital ENDOCRINOLOGY One Perkins Square Akron, OH 44308</td> <td style="width: 33%; border: none;">Fax form to: 330-543-8489</td> <td style="width: 33%; border: none;">Questions? Call: 330-543-3276</td> </tr> </table>	Mail form to: Akron Children's Hospital ENDOCRINOLOGY One Perkins Square Akron, OH 44308	Fax form to: 330-543-8489	Questions? Call: 330-543-3276
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