

Diabetes Medical Management Plan: Children's Healthcare of Atlanta, Endocrinology
 1400 Tullie Road, Atlanta, GA 30303 | 404-785-5437 | cpgdiabetes@choa.org

Child Name:		Date of Birth:
Parent Name:	Phone:	Email:
Parent Name:	Phone:	Email:

ROUTINE BLOOD SUGAR MANAGEMENT / INSULIN ADMINISTRATION

Blood Sugar Monitoring:	<input type="checkbox"/> When: <input type="checkbox"/> Before Meals <input type="checkbox"/> Before Dismissal <input type="checkbox"/> When Symptomatic <input type="checkbox"/> How: <input type="checkbox"/> Glucometer <input type="checkbox"/> Continuous Glucose Monitor
Rapid Acting Insulin:	<input type="checkbox"/> Type: <input type="checkbox"/> Humalog <input type="checkbox"/> Novolog <input type="checkbox"/> Admelog <input type="checkbox"/> Fiasp <input type="checkbox"/> Apidra <input type="checkbox"/> Delivery: <input type="checkbox"/> Insulin Pen or Vial & Syringe <input type="checkbox"/> Insulin Pump
Carbohydrate Coverage:	<input type="checkbox"/> Breakfast: Give ___ units for every ___ - ___ grams of carbohydrate <input type="checkbox"/> Lunch: Give ___ units for every ___ - ___ grams of carbohydrate <input type="checkbox"/> Snack: Give ___ units for every ___ - ___ grams of carbohydrate
Additional Mealtime Considerations:	<input type="checkbox"/> For pre-meal blood sugar > 199 at meals, give additional insulin: 200-299: ___ units 300-399: ___ units 400-499: ___ units >499: ___ units <input type="checkbox"/> For pre-meal hypoglycemia (<70), see "Management of Hypoglycemia" for treatment prior to meal. Once BG >70, give carbohydrate coverage as ordered above.

MANAGEMENT OF HYPERGLYCEMIA

For blood sugar > 300 or > 250 if on insulin pump for 2 hours	<input type="checkbox"/> Please check ketones and notify parent if ketones are present <input type="checkbox"/> Child should be allowed to stay in school or physical activity unless vomiting with moderate/large ketones present <input type="checkbox"/> Allow sugar-free fluids and bathroom privileges <input type="checkbox"/> If 2 hours since last insulin dose, please give HALF correction dose <input type="checkbox"/> If 4 hours since last insulin dose, please give FULL correction dose
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MANAGEMENT OF HYPOGLYCEMIA

Mild Low Blood Sugar (< 70)	<input type="checkbox"/> Give 15 grams of fast acting carbohydrate; recheck in 15 minutes <input type="checkbox"/> If blood sugar remains < 70, retreat and recheck in 15 minutes <input type="checkbox"/> Notify parent if hypoglycemia does not resolve and continue to treat until parent arrives or care is escalated by parent; do not leave child alone <input type="checkbox"/> If CGM alarms low after 15 minutes, repeat check on glucometer
SEVERE Low Blood Sugar (Loss of consciousness or seizure)	<input type="checkbox"/> Administer Glucagon: ___ Dose. <input type="checkbox"/> IM <input type="checkbox"/> SQ <input type="checkbox"/> Nasal <input type="checkbox"/> Call 911. Open airway. Turn to side. <input type="checkbox"/> Notify parent <input type="checkbox"/> Stop/Suspend/Disconnect insulin pump (send with EMS to hospital)

MANAGEMENT OF PHYSICAL ACTIVITY

Before Activity:	<input type="checkbox"/> Check blood sugar. <input type="checkbox"/> If blood sugar <70, follow Management of Hypoglycemia Guidelines <input type="checkbox"/> If blood sugar >300, follow Management of Hyperglycemia Guidelines <input type="checkbox"/> Have fast acting carbohydrates and monitoring supplies available <input type="checkbox"/> For pump: may suspend for 1 hour or decrease basal by ___ %
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TRAINED PROFESSIONAL SUPPORT / STUDENT INVOLVEMENT / PARENT AUTHORIZATION

Trained Professional Support (School Nurse or Trained Diabetes Personnel):	<input type="checkbox"/> Monitor blood glucose readings <input type="checkbox"/> Calculate and give / supervise insulin injections <input type="checkbox"/> Administer Glucagon when needed <input type="checkbox"/> Monitor for blood or urine ketones <input type="checkbox"/> Manage or assist with diabetes technology – pumps or CGM
Student Involvement:	<input type="checkbox"/> Monitor blood glucose: ___ in clinic office ___ in classroom ___ anywhere <input type="checkbox"/> Calculate & give insulin injections: ___ with supervision ___ independently <input type="checkbox"/> Monitor for blood or urine ketones <input type="checkbox"/> Treat hypoglycemia <input type="checkbox"/> Carry supplies for: ___ blood sugar monitoring ___ insulin administration <input type="checkbox"/> Manage technology: ___ CGM ___ Pump <input type="checkbox"/> Cell phone is used as a medical device
Parent Authorization:	<input type="checkbox"/> To increase or decrease insulin dosing +/- 15 grams of carbohydrate or ___ units of insulin

PROVIDER SIGNATURE: _____ DATE: _____

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School Year 2022-2023

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Child Name: _____	_____
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CDE: _____ DATE: _____

CDE: _____ DATE: _____

CDE: _____ DATE: _____

SIGNATURES

Certified Diabetes Educator (CDE) signatures and alterations made below are in accordance with Children’s Healthcare of Atlanta caregiver initiated protocol 7.97, CDE Insulin Management and under the supervision of provider care. Any changes outside this caregiver initiated protocol or more than two changes in a school year must be re-signed by a provider for approval. Annually, providers review and sign plans at the start of school year.

I, (Parent/Guardian) _____ Understand that all treatments and procedures may be performed by the student and/or Trained Diabetes Personnel within the school, or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by Georgia state law.

PARENT/GUARDIAN

SIGNATURE: _____ DATE: _____ TIME: _____

SCHOOL NURSE

SIGNATURE: _____ DATE: _____ TIME: _____