Diabetes Medical Management Plan: Children's Healthcare of Atlanta, Endocrinology

1400 Tullie Road, Atlanta, GA 30303 I 404-785-5437 I cpgdiabetes@choa.org

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

ROUTINE BLOOD SUGAR MANAGEMENT / INSULIN ADMINSTRATION	
Blood Sugar Monitoring:	☐ **When:** ☐ Before Meals ☐ Before Dismissal ☐ When Symptomatic ☐ **How:** ☐ Glucometer ☐ Continuous Glucose Monitor
Rapid Acting Insulin:	☐ **Type:** ☐ Humalog ☐ Novolog ☐ Admelog ☐ Fiasp ☐ Apidra ☐ **Delivery:** ☐ Insulin Pen *or* Vial & Syringe ☐Insulin Pump
Carbohydrate Coverage:	☐ **Breakfast:** Give 1 unit for every ___ grams of carbohydrate ☐ **Lunch:** Give 1 unit for every ___ grams of carbohydrate ☐ **Snack:** Give 1 unit for every ___ grams of carbohydrate
Additional Mealtime Considerations:	☐ For **pre-meal** blood sugar > 150 at meals, give additional insulin:(BG -100)/ ___ ☐ 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	☐ Please check ketones and notify parent if ketones are present ☐ Child should be allowed to stay in school or physical activity unless vomiting with moderate/large ketones present ☐ Allow sugar-free fluids and bathroom privileges ☐ If 2 hours since last insulin dose, please give HALF correction dose ☐ If 4 hours since last insulin dose, please give FULL correction dose
MANAGEMENT OF HYPOGLYCEMIA	
Mild Low Blood Sugar (< 70)	☐ Give 15 grams of fast acting carbohydrate; recheck in 15 minutes ☐ If blood sugar remains < 70, retreat and recheck in 15 minutes ☐ 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 ☐ If CGM alarms low after 15 minutes, repeat check on glucometer
SEVERE Low Blood Sugar (Loss of consciousness or seizure)	☐ Administer Glucagon: ____ Dose. ☐ IM ☐ SQ ☐ Nasal ☐ Call 911. Open airway. Turn to side. ☐ Notify parent ☐ Stop/Suspend/Disconnect insulin pump (send with EMS to hospital)
MANAGEMENT OF PHYSICAL ACTIVITY	
Before Activity:	☐ Check blood sugar. ☐ If blood sugar <70, follow Management of Hypoglycemia Guidelines ☐ If blood sugar >300, follow Management of Hyperglycemia Guidelines ☐ Have fast acting carbohydrates and monitoring supplies available ☐ For pump: may suspend for 1 hour or decrease basal by ____ %
TRAINED PROFESSIONAL SUPPORT / STUDENT INVOLVEMENT / PARENT AUTHORIZATION	
Trained Professional Support (School Nurse or Trained Diabetes Personnel):	☐ Monitor blood glucose readings ☐ Calculate and give / supervise insulin injections ☐ Administer Glucagon when needed ☐ Monitor for blood or urine ketones ☐ Manage or assist with diabetes technology – pumps or CGM
Student Involvement:	☐ Monitor blood glucose: ___in clinic office ___ in classroom ___ anywhere ☐ Calculate & give insulin injections: ___ with supervision ___ independently ☐ Monitor for blood or urine ketones ☐ Treat hypoglycemia ☐ Carry supplies for: ___ blood sugar monitoring ___ insulin administration ☐ Manage technology: ___ CGM ___ Pump ☐ Cell phone is used as a medical device

Parent Authorization:	☐ To increase or decrease insulin dosing + / - 15 grams of carbohydrate or ___ units of insulin

PROVIDER SIGNATURE: _____ DATE: _____

Diabetes Medical Management Plan: Children's Healthcare of Atlanta, Endocrinology
School Year 2022-2023

1400 Tullie Road, Atlanta, GA 30303 I 404-785-5437 I cpgdiabetes@choa.org

Child Name:	

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: _____