Westerville City Schools
Addendum for Diabetes Care
(Attach this page to Medical Providers Order)

Student Name: _____ DOB:_____

Diabetes Type: _____ Date Diagnosed: _____

School Name: _____ Homeroom Teacher:_____

Signatures

I, (parent/guardian)_____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to collaborate with my student's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian: _____ Date:_____

School Nurse or Designee: _____ Date:_____

2/24/25

Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of plan: _____ This plan is valid for the current school year: _____-_____

Student information

Student's name: _____ Date of birth: _____

Date of diabetes diagnosis:_____ ☐ Type 1 ☐ Type 2 ☐ Other: _____

School: _____ School phone number: _____

Grade: _____ Homeroom teacher: _____

School nurse:_____ Phone: _____

Contact information

Parent/guardian 1: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Parent/guardian 2: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Student's physician/health care provider: _____

Address: _____

Telephone: _____ Emergency number: _____

Email address: _____

Other emergency contacts:

Name: _____ Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Checking blood glucose

Brand/model of blood glucose meter: _____

Target range of blood glucose:

Before meals: ☐ 90–130 mg/dL ☐ Other: _____

Check blood glucose level:

☐ Before breakfast ☐ After breakfast ☐ _____ Hours after breakfast ☐ 2 hours after a correction dose

☐ Before lunch ☐ After lunch ☐ _____ Hours after lunch ☐ Before dismissal

☐ Mid-morning ☐ Before PE ☐ After PE ☐ Other: _____

☐ As needed for signs/symptoms of low or high blood glucose ☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Side of fingertip ☐ Other: _____

Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires school nurse or trained diabetes personnel to check blood glucose

☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM): ☐ Yes ☐ No Brand/model: _____

Alarms set for: Severe Low: _____ Low: _____ High: _____

Predictive alarm: Low: _____ High: _____ Rate of change: Low: _____ High: _____

Threshold suspend setting: _____

CGM may be used for insulin calculation if glucose is between ___-___ mg/dL ___Yes ___No

CGM may be used for hypoglycemia management ___ Yes ___ No

CGM may be used for hyperglycemia management ___ Yes ___ No

Additional information for student with CGM

- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-care CGM Skills: Check "Yes" or "No" if the student can perform the skill independently.

The student troubleshoots alarms and malfunctions.	☐ Yes	☐ No
The student knows what to do and is able to deal with a HIGH alarm.	☐ Yes	☐ No
The student knows what to do and is able to deal with a LOW alarm.	☐ Yes	☐ No
The student can calibrate the CGM.	☐ Yes	☐ No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ Yes	☐ No

The student should be escorted to the nurse if the CGM alarm goes off: ☐ Yes ☐ No

Other instructions for the school health team: _____

_____

Hypoglycemia treatment

Student's usual symptoms of hypoglycemia (list below): _____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment: _____

_____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- Position the student on his or her side to prevent choking.
- Administer glucagon Name of glucagon used: _____

Injection:

☐ 1 mg ☐ ½ mg ☐ Other (dose) _____

- Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
- Site for glucagon injection: ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: _____

Nasal route:

☐ 3 mg

- Route: ☐ Intranasal (IN)
- Site: ☐ Nose

- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Contact the student's health care provider.
- If on insulin pump, stop by placing mode in suspend or disconnect. Always send pump with EMS to hospital.

Hyperglycemia treatment

Student's usual symptoms of hyperglycemia (list below): _____

_____

- Check ☐ Urine ☐ Blood for ketones every _____ hours when blood glucose levels are above _____mg/dL.
- For blood glucose greater than _____mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _____ mg/dL.
- For insulin pump users: see **Additional Information for Student with Insulin Pump.**
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.

Additional treatment for ketones: _____

- Follow physical activity and sports orders. (See **Physical Activity and Sports**)

If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

Insulin therapy

Insulin delivery device: ☐ Syringe ☐ Insulin pen ☐ Insulin pump

Type of insulin therapy at school: ☐ Adjustable (basal-bolus) insulin ☐ Fixed insulin therapy ☐ No insulin

Adjustable (Basal-bolus) Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:** Name of insulin: _____
- **Carbohydrate Coverage:**

  Insulin-to-carbohydrate ratio:

  Breakfast: 1 unit of insulin per_____ grams of carbohydrate
  Lunch: 1 unit of insulin per_____ grams of carbohydrate
  Snack: 1 unit of insulin per_____ grams of carbohydrate

Carbohydrate Dose Calculation Example
Total Grams of Carbohydrate to Be Eaten ÷ Insulin-to-Carbohydrate Ratio = _____ Units of Insulin

Correction Dose: Blood glucose correction factor (insulin sensitivity factor) = _____ Target blood glucose = _____mg/dL

Correction Dose Calculation Example
(Current Blood Glucose – Target Blood Glucose) ÷ Correction Factor = _____ Units of Insulin

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose _____ to _____ mg/dL, give _____ units Blood glucose _____ to _____ mg/dL, give _____ units

Blood glucose _____ to _____ mg/dL, give _____ units Blood glucose _____ to _____ mg/dL, give _____ units

See the worksheet examples in **Advanced Insulin Management: Using Insulin-to-Carb Ratios and Correction Factors** for instructions on how to compute the insulin dose using a student's insulin-to-carb ratio and insulin correction factor.

When to give insulin:

Breakfast

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Other: _____

Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Other: _____

Snack

☐ No coverage for snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Correction dose only: For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.

☐ Other: _____

Insulin therapy (continued)

Fixed Insulin Therapy Name of insulin: _____

☐ _____ Units of insulin given pre-breakfast daily

☐ _____ Units of insulin given pre-lunch daily

☐ _____ Units of insulin given pre-snack daily

☐ Other: _____

Basal Insulin Therapy Name of insulin: _____

To be given during school hours: ___ Pre-breakfast dose: ____ units

___ Pre-lunch dose: ____ units

___ Pre-dinner dose: ____ units

Other diabetes medications:

Name: _____ Dose: _____ Route: _____ Times given: _____

Name: _____ Dose: _____ Route: _____ Times given: _____

Parents/Guardians Authorization to Adjust Insulin Dose

☐ Yes ☐ No Parents/guardians authorization should be obtained before administering a correction dose.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/ _____ grams of carbohydrate.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

Student's self-care insulin administration skills:

☐ Independently calculates and gives own injections.

☐ May calculate/give own injections with supervision.

☐ Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.

☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

Additional information for student with insulin pump

Brand/model of pump: _____ Type of insulin in pump: _____

Basal rates during school: Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____

Other pump instructions: _____

_____

Type of infusion set: _____

Additional information for student with insulin pump (continued)

Appropriate infusion site(s): _____

☐ For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.

☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Physical Activity

May disconnect from pump for sports activities:	☐ Yes, for _____ hours	☐ No
Set a temporary basal rate:	☐ Yes, _____% temporary basal for _____ hours	☐ No
Suspend pump use:	☐ Yes, for _____ hours	☐ No

Student's Self-care Pump Skills: Check "Yes" or "No" if the student can perform the skill independently.

Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alarms and malfunctions	☐ Yes	☐ No

Meal plan

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		_____ to _____
Mid-morning snack		_____ to _____
Lunch		_____ to _____
Mid-afternoon snack		_____ to _____

Other times to give snacks and content/amount: _____

_____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): _____

_____

Parent/guardian substitution of food for meals, snacks and special events/parties permitted.

Special event/party food permitted: ☐ Parents'/Guardians' discretion ☐ Student discretion

Student's self-care nutrition skills:

☐ Independently counts carbohydrates

☐ May count carbohydrates with supervision

☐ Requires school nurse/trained diabetes personnel to count carbohydrates

Physical activity and sports

A quick-acting source of glucose such as ☐ glucose tabs and/or ☐ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat ☐ 15 grams ☐ 30 grams of carbohydrate ☐ other: _____

☐ before ☐ every 30 minutes during ☐ every 60 minutes during ☐ after vigorous physical activity ☐ other: _____

If most recent blood glucose is less than _____mg/dL, student can participate in physical activity when blood glucose is corrected and above _____mg/dL.

Avoid physical activity when blood glucose is greater than _____mg/dL or if urine/blood ketones are moderate to large.

(See **Administer Insulin** for additional information for students on insulin pumps.)

Disaster/emergency and drill plan

To prepare for an unplanned disaster, emergency (72 hours) or drill, obtain emergency supply kit from parents/guardians. School nurse or other designated personnel should take student's diabetes supplies and medications to student's destination to make available to student for the duration of the unplanned disaster, emergency, or drill.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follows (e.g., dinner and nighttime): _____

_____

_____

☐ Other: _____

Signatures

This Diabetes Medical Management Plan has been approved by:

_____

Student's Physician/Health Care Provider Date

I, (parent/guardian) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) _____to perform and carry out the diabetes care tasks as outlined in (student)_____ Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

_____

Student's Parent/Guardian Date

_____

Student's Parent/Guardian Date

_____

School Nurse/Other Qualified Health Care Personnel Date

2/24/25

Westerville City School District
Remote Continuous Glucose Monitoring Agreement

School year: _____

Student Name:_____ School:_____

Student Number:_____

I, _____, request that the school nurse and/or trained clinic personnel monitor my student's, _____, blood glucose during the school day via a continuous glucose monitor (CGM) (i.e. Dexcom) **remotely** on a district device located within the school health office or with designated school personnel.

The WCSD will take the following into account based on current[1] *American Diabetes Association CGM Monitoring in the School Setting* recommendations when data sharing and monitoring is requested by the parent/guardian. The goal will be to manage diabetes needs while also promoting student wellbeing and minimizing unnecessary interruptions in the school day. The school will follow the DMMP/provider orders to use the CGM for routine, periodic, and emergent blood glucose monitoring and ensure a timely response to CGM alarms.

Please carefully review and initial the following:

_____ I understand that the school district is not responsible for providing the CGM receiver or the Bluetooth device to transmit data. A district ipad will be kept in the school health clinic or with designated school personnel for data sharing and real-time monitoring (the "Monitoring Ipad"). Multiple students may be monitored on the same school device.

_____ I agree to prepare an electronic invitation to the school nurse via the CGM (i.e. Dexcom) share application and send it via email to the clinic email provided by my student's school nurse. Staff will not follow my student's blood glucose on their personal devices.

_____ I understand the district will allow student use of the District's wireless network. I understand that the availability of this monitoring service is subject to the availability and functionality of district Wifi. The District makes no warranties, guarantees, or promises regarding the availability of wireless data while on WCSD property or otherwise.

_____ I understand that students with a device capable of sharing data may share data real time with the parent/guardian as appropriate, subject to the availability of wireless network or the student's data plan. The parent/guardian may communicate directly with clinic staff via text to the Monitoring Ipad or phone call to the clinic. In order to further more efficient communications, any text messages should be accompanied by a phone call to the school office or clinic. Speaking directly with school staff is the best way to ensure communication is received in a timely manner.

[1] The most current recommendations are dated June 20, 2024.

Westerville City School District
Remote Continuous Glucose Monitoring Agreement

_____ I agree to work with the school nurse to determine a communication plan to provide actionable updates on trends throughout the school day, if needed, and to establish expectations regarding the frequency of such communications.

_____ I understand school staff, including the school nurse and trained delegated school personnel, will respond to low and high blood glucose alarms rather than the constantly fluctuating trends and numbers. Alarm settings on the Monitoring Ipad and guidelines will be set in accordance with the provider orders and as specified in the student's individualized health care plan. Health care providers may include trend arrows in treatment orders and parents/guardians may include arrows to guide treatment in the student's individualized health care plan developed with the school nurse.

_____ I understand parents/guardians are responsible for setting the CGM alarms and notifying the school nurse of the parameters. Alarms should be set for low blood glucose and high blood glucose when treatment/action is needed. This will help the student avoid alarm fatigue and enhance learning and participation. Frequent alarms or interventions related to the CGM sensor readings can be disruptive to class time for students.

_____ I acknowledge that my student is aware of the CGM alarms, alarms will remain set, and understands to notify their teacher, school nurse, or other WCSD staff when an alarm sounds.

_____ I understand school nurses and clinic staff will make best efforts to remotely monitor CGM readings. However, school staff are responsible for keeping all students safe in the school setting. The District does not guarantee the availability of continuous remote monitoring as a result of clinic caseload, related responsibilities, or in the event of a school-related emergency. I acknowledge that no WCSD employee is responsible for and/or will constantly monitor my student's glucose on the App/Program.

My signature below indicates that I acknowledge, understand, and agree to all terms outlined above. This agreement is active for one school year and may be terminated at any time by a parent/guardian.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

School Nurse Name:_____

School Nurse Signature:_____ Date: _____

8/2024