

DIABETES MEDICAL MANAGEMENT PLAN FOR THE STUDENT WITH DIABETES ON INJECTIONS

Student:	DOB:	School:		Grade:		
Home Address:		Home Phone:	-ci	h		
Notification to Parent/Guardian: Lo	w Blood Glucose - less th	nanmg/dL	High Blood Glucose - greater tha	nmg/dL		
Continuous glucose monitoring: See continuous glucose mon	nitoring orders	W II	- 30 May 2 5 TH	Andrew Society Indian		
Hypoglycemia Mild/Moderate Treatment: less than 70 mg	/dL less than	mg/dL - Follow Rule of 15:	Treat with 2-4 Glucose Tabs	1.200maner (100		
4 ounces juice Glucose gel (use finger, place between c	heek & gum in mouth) 🗵					
IMPORTANT: Always RECHECK blood glucose in 15 minute				SS THAN mg/d		
Hypoglycemia: Severe Symptoms with loss of consciousnes Glucagon	Gvoke 🔲 0		cation aneous, Arm or Thigh			
Hyperglycemia Treatment: X Provide water and access to bat	hroom If Blood	d Glucose is greater than 250	mg/dL twice in a row:	100 PA		
IMPORTANT: Student should not be sent home from school		st urine ketones and call paren	t/guardian if ketones moderate to larg	je		
blood glucose UNLESS student is too ill to participate in sch	ool activities 📗 🔀 See	e below for insulin instructions	if applicable			
and/or has moderate ketones and vomiting present.						
When to Check Blood Glucose: Always for signs and syr		-				
☐ Before breakfast				r_11		
			ould be greater thanmg/	aL		
	glucose monitoring (CGM)		log (Asport) / Admolog / Fison			
Blood Glucose Correction and Insulin Dosage Injection site: Abdomen Arm Buttock Thigh		niections should be given subc	olog (Aspart) / Admelog / Fiasp			
Correction Factor: Give Prior to breakfast/lunch Immed		,	ulaneously and rolated			
	<u> </u>		Pland Change greater than	ADD write		
- 1/N/M1	od Glucose greater than		V mineral	ADDunits.		
	od Glucose greater than od Glucose greater than		Blood Glucose greater than	ADDunits.		
	<u>_</u>		97			
1.101 (1.101-	od Glucose greater than		-19			
	od Glucose greater than					
Blood Glucose greater thanADDunits. Bloom Parent/guardian authorized to increase or decrease total dose	od Glucose greater than	ADDunits.				
Carbohydrates and Insulin Dosage: Breakfast Snack						
		carbohydrate				
Snack: Insulin to Carbohydrate Ratiounit(s) for	-	carbohydrate carbohydrate				
	Student and Staff Togethe		ndependent			
Glucose monitoring		i Student ii	Idebetident			
Carbohydrate counting			H			
Insulin dose calculation						
Insulin administration						
Student may carry insulin with them Student may carry diabetes monitoring supplies with them Student may carry treatment for hypoglycemia						
Additional Information: Refer to student's 504 Plan for studen	at especific accommodatio	nc .				
Additional information. Refer to student's 504 Flam for studen	it specific accommodatio	115,				
Printed Name of Provider	Sigr	nature of Provider	Date	Time		
To be completed by parent/guardian: I give permission for my of	hild to receive medication a	at school according to the scho	ol 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 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. 						
This form to valid for one year from the date signed i	y rioditir oute i rovidor.	<u> </u>				
Printed Name of Parent/Guardian	Sign	nature of Parent/Guardian	Date	Time		



FM00322 Rev, 05/22



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

(Place patient label here if blank)	
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						-1	- 10.96-10.00	The state of the s
Fax to School		Family to	Pick up					
Student:			DOB:	\$	chool:		34.000	Grade:
Address:	Address:							
finger stick blood sugar Freestyle Libre are FDA blood glucose value is r unless both a blood gl CGMs contain three pa glucose levels. 2) Trans	value. It of approved equired for ucose re arts: 1) G emitter: O Receiver n	ean be progred as a replace or calibration ading and followers to be compared to be compared to be withing the progression of the compared to be withing the progression of the compared to be withing the progression of the compared to be progression of the compared to be progression of the compared to	ammed to alert (cement to fingers or if symptoms of trending arrow a sor: Placed just the sensor and son a pump, phone	vibrate or alar sticksfor use i don't match se are present. under skin by ends results to e, or electronic	n) for high and n making diabe nsor glucose re the user. The s the receiver. 3	l low gluco etes treatn eading. St ensor con B) Receive	se levels. The nent decisions i udent should tains an electro er: Shows the g	ally reads within 20% of a Dexcom G5, Dexcom G6 and ncluding dosing. A finger stick not dose off of a CGM value ode that detects changes in lucose result and allows challows the user to track
Alert Settings: A CGM	may alert	audibly if in	terstitial glucose	is outside the	parameters se	t by paren	t(s)/guardian.	
Arrows: Arrows on the)			s are changing		\bigcirc	
Glucose is rapidly rising. May increase 90 mg/dl in 30 minutes	Gluco risir May inc 60-90 r in 30 m	ng. crease ng/dL	Glucose is slowly rising. May increase 30-60 mg/dL in 30 minutes	Glucose i steady	s Glucose decrea May de 30-60 m 30 mil	asing. crease g/dL in	Glucose is decreasing May decreas 60-90 mg/dL 30 minutes	decreasing. May decrease in 90 mg/dL In
Use of a CGM at School When to check a finge • When the sensor value • If a trend arrow or significant of the symptoms do not • During sensor warm • If device indicates a	r stick bloalues is le ensor glu match pro n up perio	ss than cose is abso esentation d	or greater ent. (Both a trend		 icose reading a	are necess	sary)	
Notify Parent/Guardian • Glucose Sensor bec • Soreness, redness of CGM Malfunction	omes dis		ansmitter falls (off do not thre	ow away! Give	to family)	
Additional Information: • An individualized t • Parent(s)/guardian v • CGM reading can be • If your school has	reatment vill ensure e used for	e calibration □ Pre-ac	of CGM daily per tivity \(\sum_\) Dismis	r manufacturin sal from scho	g recommenda ol	ations al glucose		the parent(s)/guardian.
To be completed by par instructed by the Health • Assume resport • Notify the schot • Notify the schot • Allow designat	rent/guar Care Provinsibility for ol immed ol of char ed school	dian: I give rider and ag or safe delive iately if ther nges in Heal staff to sen	permission for m	ny child to rece tion in its origi in the use of the information re	ive medication nal container to is medication	at school the scho	ol	e school district policy and as appropriate.
Parent/Guardian:			WYTHE AMERICA II.		THE STATE OF THE S		***	Date:
Provider:	V/200	£	ne III-Mas Ku i	-			10	Date:



Mail forms: ATTN Endocrinology, Akron Children's Hospital One Perkins Square Akron OH 44308 Page 1 of 1

FM00321 Rev. 06/21



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

MRN
Facility Use Only

Please PRINT and fill out entirely.

nt Ition	Patient Name: Last Firs	<u> </u>	Middle	(any previous n	ame)	/ / Date of Birth
Patient Information				() (,	
Infe	Patient Street Address City		State	Zip	() Phone	
	Release Information TO Akron Children's Hospital		Stato	Zip	THORE	
e T0	Choose one: Address: Akron Campus One Perkins Square, Akron, G	DH 44308_		ng Valley Cam rket Street, Youn		<u>12</u>
Release TO	Name/Dept: Center for Diabetes & Endocr	inology	Attention:			
	(330) 543-3276 (330) 543 Phone Fax	8-8489	Endocrine Email Addre	@akronchilo	lrens.org	
5	Release FROM the following Person(s) or Organizat	ions:				
Release FROM	Name:				() Phone	
Releas					()	
	Street Address City	(State	Zip	Fax	
Purpose	Person/Place requesting records (check all th ☐ Patient/Parent/Legal Guardian ☐ Doctor/Hos		☐ Insurance Comp	any □ Other _		
Purk	Purpose of Release (check all that apply): ☑ Patient Care ☐ Disability ☐ Insurance ☐	☑ School ☐ Le	egal □ Personal Us	e □ Other _		
→	Dates of Treatment Requested:					
Information to Release	□ Medical Record Abstract – pertinent informatio used for continued care/personal use/disability. The following items are included in a Medical Recordant Property of the Visit/Discharge Summary, Emergency Reflectory & Physical, Inpatient Consult Report(s) Operative Report(s), Outpatient Clinic Note(s) Radiology Reports, Lab or Other Tests	rd Abstract: ecord	Other Information ☐ Vaccination (sho ☐ Radiology Repor ☐ Radiology Image ☐ Lab results (bloo ☐ Pathology Repor	t) records E ts E s on disc E d work)	noose any to re Billing Reco Appointmer Demograph	rds t list
Info	□ Doctor's Office Reports (Doctor or Departme	nt Name)				
	☑ Other: (please list exact documents)Any	reatment by	School Personn	<u>el</u>		
This authorization expires one year from the date of signature, OR on this date / event: Understand that treatment does not depend on me signing this Authorization. I understand that my/my child's/my ward's medical record mig information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release records may no longer be protected by Federal privacy regulations, and this person or organization might release the records to someone else, except as prohibited by 42 CFR Part 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 relevant 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 accepted the patient's health information. Signature of Patient or Parent/Legal Guardian						
/Par						
Patient	Signature of Patient or Parent/Legal Guardian My relationship to the patient is ☐ Self ☐ □		Printed Name ☑ Legal Guardian – Att	ach <u>Court Order</u>		ate hority to sign
_	Signature of Witness		Printed Name		//	/



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

MRN	
Facility Use Only	

Please PRINT and fill out entirely.

u	Potient Name:				1 1			
ent atio	Patient Name: Last	First	Middle	(any previous nan	ne) Date of Birth			
Patient Information								
P. nfo				()			
	Patient Street Address	City	State	Zip	Phone			
	Release Information TO the following Pe	rson(s) or Organizations:						
То	Name/Organization:		/School	Attention:				
e								
Release	Address	City	State	Z	Zip			
Re		`						
	Phone () Fax	Email Add	Iress				
	Person/Place requesting records (c							
Purpose	☑ Patient/Parent/Legal Guardian ☐		☐ Insurance Cor	mpany 🏻 Other				
ırpc								
Ρι	Purpose of Release (check all that a ⊠ Patient Care ☐ Disability ☐ In:		anal IT Personal I	lse □ Other				
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Method of Release	Format of records to be released: Solution on paper PDF [on CD or Jump Drive (if available)] Solution Verbal communication only with person or agency listed above							
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Met Re	Information May Be Sent Via: (Note: ☑ Mail Delivery ☑ Fax ☑ Pick Up	Radiology images can only b	<i>e placed on CD and</i> MvChart* (*electro	mailed or picked-up) onic records only size	restrictions apply)			
			,					
\rightarrow	Dates of Treatment Requested:		(If not spec	cified, the LAST 6 N	IONTHS will be released)			
4		nt information generally	Other Information	on Requested (cho	ose any to release):			
ase	used for continued care/personal use/disab The following items are included in a Me	ility.	☐ Vaccination (s		Billing Records			
ele	After Visit/Discharge Summary, Em		☐ Radiology Rep☐ Radiology Ima		Appointment list Demographics page			
0 В	History & Physical, Inpatient Consu		☐ Lab results (ble	ood work)	eg.apee page			
on t	Operative Report(s), Radiology Rep Lab or Other Tests	·OΠS,	☐ Pathology Rep					
atic			LI ACITE Records	s (specify ACI IF)				
rm	☑ Doctor's Office Reports (Doctor of the Control of the Contr	r Department Name)(Center for Diabetes	& Endocrinology				
nfo	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 Demographics page ACHP Records (specify ACHP): Demographics page ACHP Records (specify ACHP): Demographics page ACHP Records (specify ACHP):							
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_	This authorization expires one year from the	· —						
ian	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							
ard	also have information about mental health	problems or services, and/or t	reatment for alcohol	or drug abuse. I unde	rstand that if I release records to			
Gu	someone other than a doctor, insurance co Federal privacy regulations, and this person	n or organization might releas	e the records to som	eone else, except as	prohibited by 42 CFR Part 2 or other			
gal	applicable law. I understand that I can revo want to revoke it, I must notify the Privacy (
Patient/Parent/Legal Guardian	•	_	·	•				
ent/	By signing below, I affirm that I am the pati- receive the patient's health information.	ent and/or the patient's person	nal representative, ar	nd have the authority t	o authorize who may access or			
are	,							
nt/F	Signature of Patient or Parent/Legal Gua	ardian	Printed Name		///			
ıtieı	My relationship to the patient is ☐ Self			Attach <u>Court Order</u> to	show your authority to sign			
Ра					/ /			
	Signature of Witness		Printed Name		Date			
t	Submit completed form AND a copy	of a valid Photo ID (if a o	current one is not	on file with us) to				
Submit	Mail form to:	Fax form to:			Questions? Call:			
Suk	Akron Children's Hospital ENDOCRINOLOGY One Perkins Square	330 E43 0400			330 542 2276			
•,	Akron, OH 44308	330-543-8489			330-543-3276			