



DIABETES MANAGEMENT PLAN FOR STUDENTS ON INJECTIONS

Student:	DOB:	Parent phone:
School:	Phone:	Fax/Email:

BLOOD GLUCOSE MONITORING

For continuous glucose monitoring (CGM) see continuous glucose monitoring orders

Check blood sugar if feeling low / high and / or:

- Before: breakfast lunch snacks activity dismissal
 Blood sugar should be greater than ____mg/dL before: gym recess sports practice walking home riding bus

HYPOGLYCEMIA: less than 70 mg/dL less than ____ mg/dL

Give 15 gms of fast acting carbohydrates (2-4 glucose tabs, 4 oz juice, glucose gel, etc) and recheck blood sugar in 15 minutes. Repeat as needed.

- If low prior to meal: treat low first and administer insulin as instructed after low resolves
- Notify parent

SEVERE HYPOGLYCEMIA (unconscious, unresponsive, seizure, unable to swallow EVEN if blood glucose is unknown).

- Turn onto left side to prevent aspiration. Staff will use ONE form of available glucagon unless directed otherwise:
- ADMINISTER GLUCAGON AND CALL 911
- Glucagon** **GVOKE** 0.5 mg 1 mg **Baqsimi** 3 mg nasally **Zegalogue** 0.6 mg may repeat in 15 minutes

HYPERGLYCEMIA: Blood glucose > 250 mg/dL x 2 or more than 2 hours on CGM

- Check urine ketones and call parent/ guardian if moderate/ large
- Use correction scale below >2 hours since last insulin dose
- Provide water and access to bathroom

***Student should NOT be sent home unless there are moderate/large ketones with vomiting.**

INSULIN ADMINISTRATION: Apidra/ Humalog (Lispro)/ Novolog (Aspart)/ Fiasp/ Lyumjev/ Admelog Student does not receive insulin at school

- Injection Sites: arms abdomen thigh
 Administer meal- time insulin before breakfast/ lunch after breakfast/ lunch Other _____

Carbohydrate Coverage	Correction for Meals or Hyperglycemia
Breakfast: ____unit(s) for every ____gms	If blood sugar > ____ give ____ units If blood sugar > ____ give ____ units
Lunch: ____unit(s) for every ____gms	If blood sugar > ____ give ____ units If blood sugar > ____ give ____ units
Snack: ____unit(s) for every ____gms	If blood sugar > ____ give ____ units If blood sugar > ____ give ____ units
Other: ____unit(s) for every ____gms	If blood sugar > ____ give ____ units If blood sugar > ____ give ____ units
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*Parent authorized to increase or decrease insulin by 0.5 units 1 unit 2 units

ADDITIONAL MEDICATION AT SCHOOL:

Long Acting Insulin: Give ____units at _____ Other _____

Student's Care	Nurse/ Trained Staff	Supervision	Student Independent
Glucose Monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate/ Insulin Calculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Student may carry insulin glucose monitoring supplies treatment for hypoglycemia

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____ 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

- Assume responsibility for safe delivery of the medication in the 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 School Year 2026-2027.

Printed Name of Provider _____ Signature of Provider _____ Date _____ Time _____





**HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS
(TO 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 ())
Release TO	Release Information TO Akron Children's Hospital Choose one: <input checked="" type="checkbox"/> Akron Campus <input checked="" type="checkbox"/> Mahoning Valley Campus Address: <u>One Perkins Square, Akron, OH 44308</u> <u>6505 Market Street, Youngstown, OH 44512</u> Name/Dept: <u>Center for Diabetes & Endocrinology</u> Attention: _____ <u>(330) 543-3276</u> <u>(330) 543-8489</u> <u>Endocrine@akronchildrens.org</u> <small style="display: flex; justify-content: space-between; width: 100%;"> Phone Fax Email Address </small>
Release FROM	Release FROM the following Person(s) or Organizations: Name: _____ () _____ <small style="display: flex; justify-content: flex-end; width: 100%;"> Phone </small> _____ () _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Street Address City State Zip Fax </small>
Purpose	Person/Place requesting records (check all that apply): <input 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 _____
Information to Release	Dates of Treatment Requested: _____ <input 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), Outpatient Clinic Note(s) Radiology Reports, Lab or Other Tests <input type="checkbox"/> Doctor's Office Reports (Doctor or Department Name) _____ <input checked="" type="checkbox"/> Other: (please list exact documents) <u>Any Treatment by School Personnel</u> 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
Patient/Parent/Legal Guardian	This authorization expires one year from the date of signature, <u>OR</u> 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



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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 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 _____ 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): _____			
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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