This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

Diabetes Care Plan Request Form

Child's name: _____

Child's date of birth: _____

Early Learning or Child Care Program Director: Abby Maclean

Early Learning or Child Care Program: Bellevue Children's Academy - EARLY CHILDHOOD

Mailing Address: Bellevue Children's Academy - North Campus - Satellite 1, 14719 NE 29th Pl., Bellevue, WA 98007
Bellevue Children's Academy - North Campus - Satellite 2, 14673 NE 29th Pl., Bellevue, WA 98007

Phone Number: 425-649-0791 - Satellite 1 (Opt. 3); Satellite 2 (Opt. 4)

Fax Number: Satellite@bcacademy.com

Healthcare Provider: The child listed above attends our program. This packet includes forms to help meet our licensing standards for medications and individual care plans. **Please complete pages 2-5**. These are forms that require a healthcare provider's instructions and signature.

By signing below, I give permission to my child's healthcare provider to release the health information requested in the following care plan to my child's program.

Parent or Guardian Name (Printed): _____

Parent or Guardian Signature: _____

Date: _____

Parent or Guardian Phone Number: _____

American Diabetes Association.
Connected for Life.

Safe at School®

School year ____ to ____

Childcare Diabetes Medical Management Plan

CHILD'S LAST NAME: | FIRST NAME: | DOB:

PARENTS/GUARDIANS: If child is independent or partially independent, use School DMMP.

1. DEMOGRAPHIC INFORMATION—PARENT/GUARDIAN TO COMPLETE

Child's First Name: | Last Name: | DOB: | Child's Cell #: | Diabetes Type: | Date Diagnosed: Month: | Year:

Childcare Center Name and Address: | Phone #:

Child Care Center Point of Contact: | Contact Phone #:

CHILD'S SCHEDULE Arrival Time: | Dismissal Time:

Meals Times:	Time/Carbohydrate Amount:
☐ Breakfast	
☐ AM Snack	
☐ Lunch	
☐ PM Snack	
☐ Pre Dismissal Snack	
☐ Other	

Physical Activity :	Time of Day/Duration:
☐ Playground	
☐ Active Games	
☐ Sports	
☐ Additional information:	

Parent/Guardian #1 (contact first): | Relationship:

Cell #: | Home #: | Work #:

E-mail Address:

Indicate preferred contact method:

Parent/Guardian #2: | Relationship:

Cell #: | Home #: | Work #:

E-mail Address:

Indicate preferred contact method:

2. RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CHECK ALL THAT APPLY)

Symptoms of High:

☐ Thirsty ☐ Frequent Urination ☐ Fatigued/Tired/Drowsy ☐ Headache ☐ Blurred Vision ☐ Warm/Dry/Flushed Skin
☐ Abdominal Discomfort ☐ Nausea/Vomiting ☐ Fruity Breath ☐ Incontinence ☐ Temper Tantrums ☐ Behavior Changes ☐ Unaware
☐ Other:

See Section 7 for treatment.

Symptoms of Low:

☐ None ☐ Hungry ☐ Shaky ☐ Pale ☐ Sweaty ☐ Tired/Sleepy ☐ Tearful/Crying ☐ Dizzy Irritable
☐ Unable to Concentrate ☐ Confusion ☐ Personality Changes ☐ Other:

See Section 6 for treatment.

Self-management skills: ☐ Full Support ☐ Supervision ☐ Self-care
Allow child to: ☐ Select finger for BG testing ☐ Select injection site ☐ Select food-snacks ☐ Other:

Name of Health Care Provider/Clinic: | Contact #: | Fax #:

Email Address (non-essential communication): | Other:

3. GLUCOSE MONITORING

Monitor Glucose:

☐ Before Meals ☐ With Physical Complaints/Illness (include ketone testing) ☐ High or Low Glucose Symptoms
☐ Before Nap ☐ After Nap ☐ Before Physical Activity ☐ After Physical Activity ☐ Before Leaving School ☐ Other:

CONTINUOUS GLUCOSE MONITORING (CGM)

(Specify Brand & Model:

Specify Viewing Equipment: ☐ Device Reader ☐ Smart Phone ☐ Insulin Pump ☐ Smart Watch ☐ iPod/iPad/Tablet

☐ CGM is remotely monitored by parent/guardian.
☐ May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

CGM Alarms:

Low alarm mg/dL

High alarm mg/dL if applicable

☐ **Section 1-3 completed by Parent/Guardian**

Please:

- Permit access to center Wi-Fi for sensor data collection and data sharing
- Do not discard transmitter if sensor falls

Perform finger stick if:

- Glucose reading is below mg/dL or above mg/dL
- If CGM is still reading below mg/dL (DEFAULT 70 mg/dL) 15 minutes following low treatment
- CGM sensor is dislodged or sensor reading is unavailable.
- Sensor readings are inconsistent or in the presence of alerts/alarms
- Dexcom does not have both a number and arrow present
- Libre displays Check Blood Glucose Symbol
- Using Medtronic system with Guardian sensor

Notify parent/guardian if glucose is:

below mg/dL (<55 mg/dL DEFAULT)

above mg/dL (>300 mg/d DEFAULT)

4. INSULIN DOSES AT CENTER - HEALTHCARE PROVIDER TO COMPLETE

Insulin Administered Via:

☐ Syringe ☐ Insulin Pen (☐ Whole Units ☐ Half Units) ☐ Insulin Pump (Specify Brand & Model:)
☐ i-Port ☐ Smart Pen
☐ Other

☐ Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device
☐ Insulin Pump is using DIY Looping Technology (child/parent manages device independently, staff will assist with all other diabetes management)

☐ **DOSING** to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 4A).

Insulin Administration Guidelines

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with children that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when child does not complete their meal.

☐ **Prior to Meal** (DEFAULT)
☐ **After Meal** as soon as possible and within 30 minutes
☐ **Snacking** avoid snacking hours (DEFAULT 2 hours) before and after meals

Partial Dose Prior to Meal: (preferred for unpredictable eating patterns using **insulin pump therapy**)

☐ Calculate meal dose using grams of carbohydrate prior to the meal
☐ Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)
☐ May advance to Prior to Meal when child demonstrates consistent eating patterns.

For Injections, Calculate Insulin Dose To The Nearest:

☐ Half Unit (round down for < 0.25 or < 0.75 and round up for ≥ 0.25 or ≥ 0.75)
☐ Whole Unit (round down for < 0.5 and round up for ≥ 0.5)

Preferred injection site:

Additional Insulin Orders:

☐ Check for **KETONES** if child complains of physical symptoms such as nausea, vomiting, fever, or stomachache. Refer to section 7. for high blood glucose management information.

☐ Parents/guardians are authorized to adjust insulin dose +/- units

4A. DOSING TABLE—HEALTHCARE PROVIDER TO COMPLETE – SINGLE PAGE UPDATE ORDER FORM

Insulin: (administered for food and/or correction)

Rapid Acting Insulin: ☐ Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) ☐ Other:

Ultra Rapid Acting Insulin: ☐ Fiasp (Aspart) ☐ Lyumjev (Lispro-aabc) ☐ Other:

Other insulin: ☐ Humulin R ☐ Novolin R

Meal & Times	Food Dose		Glucose Correction Dose ☐ Use Formula ☐ See Sliding Scale 6B	☐ PE/Activity Day Dose
Select if dosing is required for meal	☐ **Carbohydrate Ratio:** Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	☐ **Fixed Meal Dose**	**Formula:** (Pre-Meal Glucose Reading minus **Target Glucose**) divided by **Correction Factor** = Correction Dose ☐ May give Correction dose every ____ hours as needed (DEFAULT 3 hours)	**Adjust:** ☐ **Carbohydrate Dose** ☐ **Total Dose** Indicate dose instructions below:
☐ **Breakfast**	Breakfast Carb Ratio = ____ g/unit	**Breakfast** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **AM Snack**	AM Snack Carb Ratio = ____ g/unit ☐ No Carb Dose ☐ No Insulin if < ____ grams	**AM Snack** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **Lunch**	Lunch Carb Ratio = ____ g/unit	**Lunch** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **PM Snack**	PM Snack Carb Ratio = ____ g/unit ☐ No Carb Dose ☐ No Insulin if < ____ grams	**PM Snack** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **Dinner**	Dinner Carb Ratio = ____ g/unit	**Dinner** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units

4B. CORRECTION SLIDING SCALE

☐ Meals Only ☐ Meals and Snacks ☐ Every ____ hours as needed

____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units
____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units
____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units

4C. LONG ACTING INSULIN

Time ____	☐ Lantus, Basaglar, Toujeo (Glargine) ☐ Levemir (Detemir) ☐ Tresiba (Degludec) ☐ Other ____	____ units	☐ Daily Dose	Subcutaneously

4D. OTHER MEDICATIONS

Time ____	☐ Other ____	____ units	☐ Daily Dose	Route ____

Signature is required here if sending ONLY this one-page dosing update.

Diabetes Provider Signature: ____ **Date:** ____

5. LOW GLUCOSE PREVENTION (HYPOGLYCEMIA)

Allow Early Interventions

☐ Give Mini-Dosing of carbohydrate (i.e.,1-2 glucose tablets; glucose gel to infants) when low glucose is predicted, sensor readings are dropping (down arrow) at _____ mg/dL (DEFAULT 80 mg/dL or 120 mg/dL prior to physical activity) or with symptoms.

☐ Allow child to carry and consume snacks ☐ Childcare staff to administer

☐ Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (DEFAULT)

Insulin Management (Insulin Pumps)

Temporary Basal Rate Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia.

☐ Pre-programmed Temporary Basal Rate Named _____ (Omnipod)

☐ Temp Target (Medtronic) ☐ Exercise Activity Setting (Tandem)

☐ Activity Feature (Omnipod 5) ☐ None available, disconnect from pump (iLet)

Start: _____ minutes prior to physical activity for _____ minutes duration (DEFAULT 1 hour prior, during, and 2 hours following physical activity).

Initiated by: ☐ Trained Staff ☐ Nurse/health care provider

☐ May disconnect and suspend insulin pump up to _____ minutes (DEFAULT 60 minutes) to avoid hypoglycemia, personal injury with certain physical activities or damage to the device (keep in a cool and clean location away from direct sunlight).

Physical Activity is a very important part of diabetes management and should always be encouraged and facilitated).

Physical Activity Monitoring

☐ prior to physical activity ☐ every 30 minutes during extended physical activity ☐ following physical activity with symptoms

Delay physical activity if glucose is < _____ **mg/dL (120 mg/dL DEFAULT)**

Pre-Physical Activity Routine

☐ **Fixed Snack:** Provide _____ grams of carbohydrate prior to physical activity if glucose < _____ mg/dL

☐ **Added Carbs:** If glucose is < _____ mg/dL (120 DEFAULT) give _____ grams of carbohydrates (15 DEFAULT)

☐ **TEMPORARY BASAL RATE as indicated above**

Encourage and provide access to water for hydration, carbohydrates to treat/prevent hypoglycemia, and bathroom privileges during physical activity

6. LOW GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Low Glucose below _____ mg/dL (below 70 mg/dL DEFAULT) or below _____ mg/dL before/during physical activity (DEFAULT is < 120 mg/dl).

1. If child is awake and able to swallow give _____ grams of fast acting carbohydrate (DEFAULT 15 grams). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.
   ☐ Parent may change amount given
2. Check blood glucose every 15 minutes and re-treat until glucose > _____ mg/dL (DEFAULT is 80 mg/dL or 120 mg/dL before physical activity).

SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)
Administer Glucagon, position child on their side and monitor for vomiting, call 911 and notify parent/guardian. If BG meter is available, confirm hypoglycemia via BG fingerstick. Do not delay treatment if meter is not immediately available. If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with child.

☐ Gvoke PFS (prefilled syringe) by SC Injection ☐ 0.5 mg ☐ 1.0 mg

☐ Gvoke HypoPen (auto-injector) by SC Injection ☐ 0.5 mg ☐ 1.0 mg

☐ Gvoke Kit (ready to use vial and syringe, 1mg/0.2 ml) by SC injection

☐ Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector ☐ Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe

☐ Baqsimi Nasal Glucagon 3 mg

7. HIGH GLUCOSE MANAGEMENT (HYPERGLYCEMIA)

Management of High Glucose over _____ mg/dL if within _____ hours of food intake. (Default is 300 mg/dL OR 250 mg/dl if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 30 minutes. May consume fluids in classroom. Provide carbohydrate free snacks, if hungry. Allow frequent bathroom privileges.
2. Check for Ketones (before giving insulin correction)
   a. If Trace or Small Urine Ketones (0.1 – 0.5 mmol/L if measured in blood)
      - Consider insulin correction dose. Refer to the "Correction Dose" Section 4.A-B. for designated times correction insulin may be given.
      - *Can remain at center*
      - Recheck glucose and ketones in 2 hours
   b. If Moderate or Large Urine Ketones (0.6 – 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.
      - Contact parents/guardian or, if unavailable, healthcare provider
      - **Administer correction dose via injection.** If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the "Blood Glucose Correction Dose" Section 4.A-B
      - **If using insulin pump, change infusion site/cartridge or use injections until dismissal.**
      - No physical activity until ketones have cleared
      - Report nausea, vomiting, and abdominal pain to parent/guardian to take child home.
      - Call 911 if changes in mental status and labored breathing are present and notify parents/guardians.

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

Child's Physician/Health Care Provider: _____ Date: _____

I, (parent/guardian) _____ give permission to child care center owner, qualified health care professional or trained employees of (center name) _____ perform and carry out the diabetes care tasks as outlined in this childcare Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all center employees 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 child care center owner or qualified health care professional to collaborate with my child's physician/health care provider.

Acknowledged and received by:

Child's Parent/Guardian: _____ Date: _____

Acknowledged and received by:

Childcare Center Representative: _____ Date: _____

This page to be completed by:
Healthcare Provider

Public Health
Seattle & King County

3-Day Critical Medication Authorization Form

Healthcare Provider and Parent or Guardian: In the event the child needs to remain at the program past usual hours, a 3-day supply of Critical Medication(s) must be kept at the program. This life-sustaining medication is usually given when the child is not in care. Examples may include certain diabetes, seizure, or asthma medications. A new 3-Day Critical Medication Authorization Form should be completed if there are changes to the medication or child's health condition.

Program Staff: This life-sustaining medication will only be given if the child needs to remain at the program past usual hours. Each 3-Day Critical Medication must have its own 3-Day Critical Medication Authorization Form. Never give an expired medication. An expired medication must be replaced, and the updated expiration date must be added to this form.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Reason for medication: _____

Possible side effects of medication: _____

Medication expiration date: _____

When to give medication (do not write 'as needed' or 'ongoing'; list symptoms or times of day to give the medication)**:** _____

How much medication to give (must include dose of medication)**:** _____

How long to give medication (do not write 'as long as needed' or 'ongoing'; write a date to stop giving medication, no longer than 1 year)**:** _____

How to give the medication (for example: by mouth [oral], on skin [topical], injection, etc.)**:** _____

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3-Day Critical Medication Authorization Form (Continued)

Medication requires special storage: ☐ Yes ☐ No

If yes, specify (for example: refrigerate; keep away from light; etc.)**:**_____

Additional instructions: _____

Parent or Guardian: By signing below, I give the program permission to give this medication to my child as described on this 3-Day Critical Medication Authorization Form.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

Healthcare Provider: By signing below, I acknowledge that this child requires a 3-Day supply of critical medication to be stored at the child's program**. It will only be given in the event the child needs to remain at the program past usual hours.**

Healthcare Provider Name (Printed): _____

Healthcare Provider Signature: _____

Healthcare Provider Phone Number: _____

Date: _____

This page to be completed by:
Program Staff and Parent or Guardian

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Additional Requirements for Care Plans

Child's name: _____

Program Staff and Parent or Guardian: The WAC requires that all care plans include the potential side effects and expiration date of medications. If this is not included in the care plan, write them in the table below. **You may find this information on the medication packaging or label.**

Medication Name	Expiration Date	Potential Side Effects

Program Staff and Parent or Guardian: The WAC requires a parent**,** guardian, or appointed designee to provide training to program staff about medication administration or special medical procedures listed in the child's care plan. **Use the space below to document this training.**

Employee Training Record				
Date of Training	**Employee Name (Printed)**	**Employee Signature**	**Trainer Name (Printed)**	**Trainer Signature**

Program Staff and Parent or Guardian: The WAC requires written consent from a child's parent or guardian before a program can administer any medications or follow a care plan that is completed by a healthcare provider. **Please have the parent or guardian sign below.**

By signing below, I give the program permission to follow this care plan as ordered by the healthcare provider.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

This page to be completed by:
Parent or Guardian

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Emergency Contact Information

Child's name: _____

Parent or Guardian: If your child has a medical emergency, program staff need to be able to contact you or another emergency contact as quickly as possible. Please complete the following:

Emergency Contact #1

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #2

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #3

Name: _____

Relationship to Child: _____

Phone Number: _____

This page to be completed by:
Program Staff

Public Health
Seattle & King County

Medication Log

Program Staff: Please print a Medication Log for each medication (including any 3-Day Critical Medication).

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Date	Time	Dose	Person Giving Medication (*Initials)	Reason Medication Was Not Given	Observed Side Effects

Initials*	Printed Name and Signature of Person Giving Medications