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: _____

NDEP National Diabetes Education Program
A program of the National Institutes of Health and the Centers for Disease Control and Prevention

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 a 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: _____

Additional information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level. If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the 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	Independent?	
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.
- Give glucagon: ☐ 1 mg ☐ ½ mg ☐ Other (dose) _____
  - Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
  - Site for glucagon injection: ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: _____
- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Contact the student's health care provider.

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

Insulin therapy (continued)

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
$\frac{\textit{Total Grams of Carbohydrate to Be Eaten}}{\textit{Insulin-to-Carbohydrate Ratio}} = ____\ \textit{Units of Insulin}$

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

Correction Dose Calculation Example
$\frac{\textit{Current Blood Glucose – Target Blood Glucose}}{\textit{Correction Factor}} = ____\ \textit{Units of Insulin}$

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: _____

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: _____

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

Additional information for student with insulin pump (continued)

Student's Self-care Pump Skills	Independent?	
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

Other diabetes medications

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

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

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): _____

_____

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 plan

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

☐ 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 Signature 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 Signature Date

_____

Student's Parent/Guardian Date

_____

School Nurse/Other Qualified Health Care Personnel Date

NDEP National Diabetes Education Program
A program of the National Institutes of Health and the Centers for Disease Control and Prevention

Hypoglycemia Emergency Care Plan (For Low Blood Glucose)

Student's Name: _____

Grade/Teacher: _____

Date of Plan: _____

Emergency contact information

Parent 1/Guardian: _____

Email Address: _____ Home Phone: _____

Work Phone: _____ Mobile: _____

Parent 2/Guardian: _____

Email Address: _____ Home Phone: _____

Work Phone: _____ Mobile: _____

Health Care Provider: _____

Phone Number: _____

School Nurse: _____

Contact Number(s): _____

Trained Diabetes Personnel: _____

Contact Number(s): _____

The student should never be left alone, or sent anywhere alone or with another student, when experiencing hypoglycemia.

Causes of Hypoglycemia	Onset of Hypoglycemia
• Too much insulin • Missing or delaying meals or snacks • Not eating enough food (carbohydrates) • Getting extra, intense, or unplanned physical activity • Being ill, particularly with gastrointestinal illness	• Sudden—symptoms may progress rapidly

NDEP National Diabetes Education Program
A program of the National Institutes of Health and the Centers for Disease Control and Prevention

Hypoglycemia Symptoms	
Circle student's usual symptoms.	
Mild to Moderate	**Severe**
• Shaky or jittery • Sweaty • Hungry • Pale • Headache • Blurry vision • Sleepy • Dizzy • Lightheaded • Confused • Disoriented • Uncoordinated • Irritable or nervous • Argumentative • Combative • Changed personality • Changed behavior • Inability to concentrate • Weak • Lethargic • Other: _____	• Inability to eat or drink • Unconscious • Unresponsive • Seizure activity or convulsions (jerking movements)

Actions for Treating Hypoglycemia	
Notify school nurse or trained diabetes personnel as soon as you observe symptoms. If possible, check blood glucose (sugar) at side of finger. Treat for hypoglycemia if blood glucose level is less than _____ mg/dL. **WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.**	
Treatment for Mild to Moderate Hypoglycemia	**Treatment for Severe Hypoglycemia**
☐ Provide quick-acting glucose (sugar) product equal to _____ grams of carbohydrates. Examples of 15 grams of carbohydrates are listed below: • 4 glucose tablets • 1 tube of glucose gel • 4 ounces of fruit juice (not low-calorie or reduced-sugar) • 4–6 ounces (1/2 can) of soda (not low-calorie or reduced-sugar) ☐ Wait 15 minutes. ☐ Recheck blood glucose level. ☐ Repeat quick-acting glucose product if blood glucose level is less than _____mg/dL. ☐ Contact the student's parents/guardians. ☐ Once the student's blood glucose returns to normal, check the blood glucose level 1 hour later. Provide an additional source of carbohydrate (e.g., whole grain crackers, graham crackers, granola bar, yogurt, or fruit) if a meal or snack is not planned.	☐ Position the student on his or her side. ☐ Do not attempt to give anything by mouth. ☐ Administer glucagon: _____ mg at _____ site. ☐ While treating, have another person call 911 (Emergency Medical Services). ☐ Contact student's parents/guardians. ☐ Stay with student until Emergency Medical Services arrive. ☐ Notify student's health care provider.

Hyperglycemia Emergency Care Plan (For High Blood Glucose)

Student's Name: _____

Grade/Teacher: _____

Date of Plan: _____

Emergency contact information

Parent 1/Guardian: _____

Email Address: _____ Home Phone: _____

Work Phone: _____ Mobile: _____

Parent 2/Guardian: _____

Email Address: _____ Home Phone: _____

Work Phone: _____ Mobile: _____

Health Care Provider: _____

Phone Number: _____

School Nurse: _____

Contact Number(s): _____

Trained Diabetes Personnel: _____

Contact Number(s): _____

Causes of Hyperglycemia	Onset of Hyperglycemia
• Too little insulin or other blood glucose-lowering medications • Insulin pump or infusion set malfunction • Food intake that has not been covered adequately by insulin • Decreased physical activity • Illness • Infection • Injury • Severe physical or emotional stress	• Over several hours or days

NDEP National Diabetes Education Program
A program of the National Institutes of Health and the Centers for Disease Control and Prevention

Hyperglycemia Symptoms	**Hyperglycemia Emergency Symptoms** Diabetic ketoacidosis (DKA), which is associated with hyperglycemia, ketosis, and dehydration
Circle student's usual signs and symptoms.	
• Increased thirst and/or dry mouth • Frequent or increased urination • Change in appetite and nausea • Blurry vision • Fatigue • Other: _____	• Dry mouth, extreme thirst, and dehydration • Nausea and vomiting • Severe abdominal pain • Fruity breath • Heavy breathing or shortness of breath • Chest pain • Increasing sleepiness or lethargy • Depressed level of consciousness

Actions for Treating Hyperglycemia	
Notify school nurse or trained diabetes personnel as soon as you observe symptoms.	
Treatment for Hyperglycemia	**Treatment for Hyperglycemia Emergency**
☐ Check the blood glucose level. ☐ Check urine or blood for ketones if blood glucose levels are greater than _____ mg/dL. ☐ Calculate the Insulin Correction Dose needed as specified in the DMMP. ☐ Administer supplemental insulin dose: _____. (If student uses a pump, see instructions below.) ☐ Give extra water or non-sugar-containing drinks (not fruit juices): _____ ounces per hour. ☐ Allow free and unrestricted access to the restroom. ☐ Recheck blood glucose every 2 hours to determine if decreasing to target range of _____ mg/dL. ☐ Restrict participation in physical activity if blood glucose is greater than _____ mg/dL and if ketones are moderate to large. ☐ Notify parents/guardians if blood glucose is greater than _____ mg/dL or if ketones are present. **For Students Using an Insulin Pump** • If student uses a pump, check to see if the pump is connected properly and functioning by giving a correction bolus through the pump and checking the blood glucose 1 hour later. • If moderate or large ketones are present, treat ketones with a subcutaneous injection of insulin, then change pump site or initiate pump back-up plan. • For infusion site failure: insert new infusion set and/or replace reservoir or pod, or give insulin by syringe or pen. • For suspected pump failure: suspend or remove pump and give insulin by syringe or pen.	☐ Call parents/guardians, student's health care provider, and 911 (Emergency Medical Services) right away. ☐ Stay with student until Emergency Medical Services arrive.

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Edmond Public Schools **Fax #** _____

One Medication per Form

Authorization and request for the administration of medication at school for prescription and/or non-prescription medication.

Student_____ **Birthdate**_____ **Grade**_____ **School Year** _____

School_____ **Teacher**_____ **Date received** _____

- **TO BE COMPLETED BY THE LICENSED PHYSICIAN OR PRESCRIBER**

1. **Reason for medication** _____
2. **Name of medication** _____
3. **Dosage** _____
4. **Time to be administered** _____
5. **Duration (week, month, indefinite, etc.)** _____
6. **Side Effects: ☐ None Expected ☐ Specify** _____

   _____
7. **Form of medication/treatment: Tablet____ Liquid____ Inhaler____ Injection____ Nebulizer____ Other_____**
8. **Special storage requirements: None _____ Refrigerate _____**

_____ _____ _____

Licensed Prescriber Signature **Name (please print)** **Date**

_____ _____ _____

Address **Phone** **Fax**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request and give my permission for the above named school to administer the medication prescribed on this form. Prescription medication must have the pharmacy label attached and must match the written prescriber order. "Over the counter medication" must be in the original, unopened container. All medication must be brought to school by an adult. I further understand that I will be responsible for picking up any remaining medication at the end of the school year; medication will NOT be sent home with students. Any medication remaining after the school year has ended will be discarded utilizing proper procedure. The school nurse may consult with the prescriber regarding this prescription. Changes to the time and/or dosage of the medication require written authorization from the licensed prescriber and parent/guardian.

_____ _____

Parent/Guardian Signature **Date**

COMPLETE THE SECTION BELOW ONLY IF PRESCRIBING ASTHMA, ANAPHYLAXIS OR DIABETES MEDICATION TO BE CARRIED BY THE STUDENT

SELF-ADMINISTRATION OF ASTHMA, ANAPHYLAXIS, AND DIABETES MEDICATION ONLY

TO BE COMPLETED BY THE LICENSED PHYSICIAN/PRESCRIBER:

- **This student has been instructed and is capable and responsible to self-administer this medication: Yes ____ No ____**
- **This student may carry this medication on their person: Yes____ No____**

_____ _____

Licensed Prescriber Signature (Required) **Date**

- **TO BE COMPLETED BY THE PARENT/GUARDIAN:**

Authorization for Self-Administration of Medication

THE SCHOOL DISTRICT SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY MY STUDENT/CHILD. PURSUANT TO OKLAHOMA LAW, I UNDERSTAND I AM *REQUIRED TO PROVIDE THE SCHOOL WITH AN EMERGENCY SUPPLY OF THE MEDICATION(S).*

_____ _____

Parent/Guardian Signature **Date**

I will not knowingly share my medication with another student.

_____ _____

Student Signature **Date**