

DIABETES MEDICAL MANAGEMENT PLAN

The student's healthcare provider and parents/guardians should complete this form. Please fill out entire form. Review with relevant school personnel who have an educational and safety interest in students with diabetes. Keep copies to share with the school nurse, trained school personnel, and other authorized personnel.

Current Date _____

Student Information

Student Name: _____ Date of Birth: _____
School Grade No.: _____ Homeroom Teacher: _____
School Name: _____ School District: _____

Type of Diabetes: _____ Date Diagnosed: _____ Last A1C result: _____ A1C Goal: _____

Parent/Guardian Contact Information

Mother/Guardian: _____
Email: _____
Address: _____
Telephone: Home () _____ Work () _____ Cell () _____
Father/Guardian: _____
Email: _____
Address: _____
Telephone: Home () _____ Work () _____ Cell () _____

Health Care Provider and Emergency Contact Information

Student's Primary Health Care Provider: _____ Telephone: () _____
Nurse: _____ Telephone: () _____
Endocrine Specialist: _____ Telephone: () _____
Certified Diabetes Educator: _____ Telephone: () _____
Additional Emergency Contact: _____ Relationship: _____
Address: _____
Telephone: Home () _____ Work () _____ Cell () _____
Preferred Hospital: _____

Notify parents/guardians or additional emergency contact in the following situation(s):

- 1) _____
- 2) _____
- 3) _____
- 4) _____

LOW BLOOD GLUCOSE/HYPOGLYCEMIA

Symptoms of low blood glucose (check most common for student):

MILD to...

MODERATE to...

SEVERE

- | | | |
|---|---|---|
| <input type="checkbox"/> Hungry | <input type="checkbox"/> Mood/behavior change | <input type="checkbox"/> Confused/unable to follow commands |
| <input type="checkbox"/> Shaky/weak/clammy | <input type="checkbox"/> Inattentive/spacey | <input type="checkbox"/> Unable to swallow |
| <input type="checkbox"/> Blurred vision/glassy eyes | <input type="checkbox"/> Slurred/garbled speech | <input type="checkbox"/> Unable to awaken (unconscious) |
| <input type="checkbox"/> Dizzy/headache | <input type="checkbox"/> Anxious/irritable | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Sweaty/flushed/hot | <input type="checkbox"/> Numbness or tingling around lips | <input type="checkbox"/> Convulsion |
| <input type="checkbox"/> Tired/drowsy | <input type="checkbox"/> Poor coordination | |
| <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> Unable to concentrate | |
| <input type="checkbox"/> Pale skin color | <input type="checkbox"/> Personality change | |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Usually has no symptoms | <input type="checkbox"/> Usually has no symptoms | |

Treatment of low blood glucose TREAT IF blood sugar is less than _____ mg/dL (Check all that apply):

- Give _____ grams carbohydrate of one of the following (check all that apply):
- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> _____ oz milk | <input type="checkbox"/> _____ grams of glucose gel | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> _____ oz fruit juice | <input type="checkbox"/> _____ glucose tablets | <input type="checkbox"/> Other: _____ |
- Recheck blood glucose in 15 minutes **OR** Other: _____
- If blood glucose is less than _____ mg/dL, give another _____ grams of carbohydrate
- Students using a continuous glucose monitor must always use a finger stick glucose reading to confirm low blood glucose.*

GLUCAGON (check all that apply):

Not applicable

- Administer Glucagon if student is: confused/unable to follow commands, unable to swallow, unable to awaken (unconscious), or having a seizure or convulsion

Glucagon Dose (check): 0.5 mg or 1.0 mg Injection site (check): arm thigh other _____

If student uses an insulin pump and exhibits symptoms of severe low blood glucose, in addition to giving Glucagon:

- Disconnect tubing from student Suspend insulin pump Other: _____

HIGH BLOOD GLUCOSE/HYPERGLYCEMIA

Symptoms of high blood glucose (check most common for student):

MILD to...

MODERATE to...

SEVERE

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent urination/bedwetting | <input type="checkbox"/> Mild symptoms, and | <input type="checkbox"/> Mild and moderate symptoms, and |
| <input type="checkbox"/> Extreme thirst/dry mouth | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Labored breathing |
| <input type="checkbox"/> Sweet, fruity breath | <input type="checkbox"/> Stomach pain/cramps | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Tiredness/fatigue | <input type="checkbox"/> Dry/itchy skin | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Increased hunger | <input type="checkbox"/> Unusual weight loss | <input type="checkbox"/> Unconsciousness |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Flushed skin | | |
| <input type="checkbox"/> Lack of concentration | | |
| <input type="checkbox"/> Other: _____ | | |

Treatment of high blood glucose (check all that apply):

- Provide correction/supplemental dose of insulin (see *Insulin and Insulin Pump sections*)
- If blood glucose is: _____ mg/dL **and/or** if student is sick ⇒ **check ketones** in (check): urine blood
- Blood glucose ≥ _____ mg/dL **without ketones** recheck blood glucose level in (check): 2 hour
- Blood glucose ≥ _____ mg/dL **with ketones** (check below):

If ketones are:

Trace/Small

Moderate/Large

- | | |
|---|---|
| <input type="checkbox"/> Allow free bathroom access | <input type="checkbox"/> Allow free bathroom access |
| <input type="checkbox"/> Encourage water and/or other sugar-free fluids | <input type="checkbox"/> Encourage water and/or other sugar-free fluids |
| <input type="checkbox"/> Recheck blood glucose levels in 2 hours | <input type="checkbox"/> Call parents/guardians |
| <input type="checkbox"/> Recheck ketones in 2 hours | <input type="checkbox"/> Arrange for student to be taken home and/or to see his/her healthcare provider |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Students using a continuous glucose monitor must always use a finger stick glucose reading to confirm high blood glucose.

BLOOD GLUCOSE MONITORING

Not applicable

Name of glucose monitor: _____

Student will test at school. Yes No

Student can perform own blood glucose check. Yes No Exceptions: _____

Target blood glucose range: _____ to _____ mg/dL

Routine glucose monitoring at school (check all that apply):

- Before breakfast
- Before morning snack
- Before lunch
- Before afternoon snack

Additional glucose monitoring at school (check all that apply):

- Before physical activity/physical education
- During physical activity/physical education
- After physical activity/physical education
- Symptoms of high blood glucose
- Symptoms of low blood glucose
- When student is sick

CONTINUOUS GLUCOSE MONITORS (CGM)

Not applicable

Treatment decisions and diabetes care plan adjustments should never be made based on CGM results.

Name of CGM: _____

- CGM alert for low blood glucose is set at _____ mg/dL
- CGM alert for high blood glucose is set at _____ mg/dL

Check blood glucose by finger stick in these situations (check all that apply):

- Any high or low glucose alert
- Before insulin or medication is used to lower glucose
- Any symptoms of low or high blood glucose
- Any time the CGM system is not working

Additional comments:

SICK DAY

If a Student comes to school sick or becomes sick at school (do the following):

- Check blood glucose
- Offer sugar-free fluids
- Arrange for student to be excused from school
- Check ketones
- Call parents/guardians
- Other: _____

DIABETES SUPPLIES TO BE KEPT AT SCHOOL

- Blood glucose monitor, blood glucose test strips, batteries for monitor
- Fast-acting source of glucose
- Lancet device, lancets, gloves
- Carbohydrate containing snack
- Urine/blood ketone testing supplies
- Glucagon emergency kit
- Insulin vials and syringes
- Other: _____
- Insulin pump supplies
- Other: _____
- Insulin pen, pen needles, insulin cartridges
- Other: _____

ORAL MEDICATION

Not applicable

Name of medication, dose and schedule (list):

1. _____
2. _____
3. _____
4. _____

INSULIN **Not applicable**

Insulin required and delivered by (check): Syringe/Vial Pre-filled Syringe Insulin Pen Insulin Pump

Type of Insulin used:

Rapid/short: Humalog / Novolog / Apidra (*circle*) Intermediate/NPH: Humulin / Novolin (*circle*)
 Regular: Humulin / Novolin (*circle*) Long: Glargine (Lantus) / Detemir (Levemir) (*circle*)

Insulin to be given by: Approved School Personnel Student Parent Other _____

Student skills for using insulin (check all that apply):

Counts and calculates carbohydrates Draws up correct insulin dose
 Determines correct insulin dose for carbohydrates consumed Gives own injection

Insulin required for (check): Breakfast AM Snack Lunch PM Snack Other _____

Give Insulin (check): Before eating (eat within 5 minutes) After eating (give insulin 10 minutes after meal)

Insulin Dose for Meals Fixed Insulin Dose **OR** Flexible Insulin Dose

• FIXED Insulin Dose:

_____ units, if blood glucose is _____ to _____ mg/dL _____ units, if blood glucose is _____ to _____ mg/dL
 _____ units, if blood glucose is _____ to _____ mg/dL _____ units, if blood glucose is _____ to _____ mg/dL
 _____ units, if blood glucose is _____ to _____ mg/dL _____ units, if blood glucose is _____ to _____ mg/dL

• FLEXIBLE Insulin Dose: (Total dosage of insulin = insulin for food + correction insulin dose):

_____ units per carbohydrate serving **OR** 1 unit for _____ grams of carbohydrate

A standard insulin correction dose is _____ units per _____ mg/dL above _____ mg/dL

Insulin Correction Scale:

_____ units, if blood glucose is _____ to _____ mg/dL _____ units, if blood glucose is _____ to _____ mg/dL
 _____ units, if blood glucose is _____ to _____ mg/dL _____ units, if blood glucose is _____ to _____ mg/dL
 _____ units, if blood glucose is _____ to _____ mg/dL _____ units, if blood glucose is _____ to _____ mg/dL

Insulin for Correction: Non Meal Time Not applicable Applicable (*see options and criteria below*):

Options: Use insulin correction scale above Use calculated insulin correction dose above

Criteria for giving extra insulin for correction (check all that apply):

Extra insulin is given if it has been more than 2 hours since last dose was given and it is not a meal Blood glucose must be checked in 2 hours after correction dose is given
 Blood glucose level is over _____ mg/dL Notify parents when extra doses are given at school
 Do not exceed 2 extra doses in one school day Other _____

Insulin Pump: Not applicable Applicable (*continue below*)

Insulin for Pump: Used Bolus Calculator **OR** Bolus dosage as indicated below

Breakfast: _____ units/gram	Afternoon snack: _____ units/gram
Morning snack: _____ units/gram	Dinner: _____ units/gram
Lunch: _____ units/gram	Evening snack: _____ units/gram

Student pump abilities/skills (check all that apply):

Counts and calculates carbohydrates Disconnects pump
 Boluses correct amount for carbohydrate consumed Reconnects pump infusion set
 Changes infusion set/prepares reservoir and tubing Performs temporary basal changes
 Inserts new infusion set Troubleshoots alarms or malfunctions

Student may disconnect insulin pump during (*check all that apply*): Vigorous sports Shower Other _____

If insulin pump fails for any reason, call parents/guardians/healthcare provider (see insulin correction dose above)

SIGNATURE ADDENDUM

This is an addendum to the original Diabetes Medical Management Plan. The changes listed above for the Insulin and Insulin Pump sections replaces any previous information.

SIGNATURE – Heath Care Provider _____ Date _____

SIGNATURE – Parent/Guardian _____ Date _____

MEALS/SNACKS AT SCHOOL

Student independently calculates the amount of carbohydrate in meals/snacks. Yes No

Student may eat carbohydrates as desired Yes No (If no, indicate amounts below)

Common Carbohydrate Amounts and Timing of Meals/Snack;

Breakfast: _____ grams at _____ am Morning snack: _____ grams at _____ am/pm
Lunch: _____ grams at _____ am/pm Afternoon snack: _____ grams at _____ pm

Additional snack(s) required; Before physical activity After physical activity Other: _____

Preferred snack foods (*list*): _____

Food allergies: _____

Foods to avoid (*if any*): _____

List food options for school parties and special school events:

Option 1: _____

Option 2: _____

Note: For Students using Insulin refer to prior Insulin section of this form.

PHYSICAL ACTIVITY/SPORTS

Have fast-acting carbohydrates available at times of physical activity and sports.

Student **should not** exercise/engage in physical activity if ketones are (*circle all that apply*): trace / small / moderate / large

Student **should not** exercise/engage in physical activity: If blood glucose is greater than _____ mg/dL

If blood glucose is less than _____ mg/dL

ALL SCHOOL-SPONSORED ACTIVITIES

(e.g., field trips, extracurricular activities, etc.)

Notify family of activities in order to preplan by: 1 week 2 weeks Other: _____

The following diabetes supplies should be available to the student during school-sponsored activities:

- | | |
|--|---|
| <input type="checkbox"/> A copy of the student's Diabetes Medical Management Plan (DMMP), Section 504 Plan, Emergency Action Plan, and Healthcare Plan | <input type="checkbox"/> Injection/insulin pump supplies and insulin with appropriate storage to prevent spoilage of insulin (if using insulin) |
| <input type="checkbox"/> Blood glucose monitor and test strips | <input type="checkbox"/> Bag lunch or snack (optional) |
| <input type="checkbox"/> CGM sensor information | <input type="checkbox"/> Glucagon kit (if using insulin) |
| <input type="checkbox"/> Fast-acting carbohydrate source (e.g., milk, fruit juice, glucose gel, glucose tablets) | <input type="checkbox"/> Other: _____ |

I have reviewed and approved the Diabetes Medical Management Plan (DMMP). This DMMP shall remain in effect through the end of the current school year unless discontinued or changed in writing. I understand the DMMP or appropriate parts of the DMMP will be shared with relevant school personnel.

SIGNATURE – Health Care Provider _____ **Date** _____

SIGNATURE – Health Care Provider _____ **Date** _____

SIGNATURE – Parent/Guardian _____ **Date** _____

SIGNATURE – Parent/Guardian _____ **Date** _____

Update this plan (*check all that apply*):

Any time there are treatment changes 3 months 6 months Start of School year Other _____