

Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardian. 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'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

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell: _____

Email Address: _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell: _____

Email Address: _____

Student's Physician/Health Care Provider: _____

Address: _____

Telephone: _____

Email Address: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____ Relationship: _____

Telephone: Home _____ Work _____ Cell: _____

CHECKING BLOOD GLUCOSE

Target range of blood glucose: 70–130 mg/dL 70–180 mg/dL

Other: _____

Check blood glucose level: Before lunch _____ Hours after lunch

2 hours after a correction dose Mid-morning Before PE After PE

Before dismissal Other: _____

As needed for signs/symptoms of low or high blood glucose

As needed for signs/symptoms of illness

Preferred site of testing: Fingertip Forearm Thigh Other: _____

Brand/Model of blood glucose meter: _____

Note: 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 school nurse or trained diabetes personnel to check blood glucose

Continuous Glucose Monitor (CGM): Yes No

Brand/Model: _____ Alarms set for: (low) and (high)

Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

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 10–15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment: _____

HYPOGLYCEMIA TREATMENT (Continued)

Follow physical activity and sports orders (see page 7).

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
- Glucagon: 1 mg 1/2 mg Route: SC IM
- Site for glucagon injection: arm thigh Other: _____
- Call 911 (Emergency Medical Services) and the student’s parents/guardian.
- Contact 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 orders below).

For insulin pump users: see additional information for student with insulin pump.

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 page 7).

- Notify parents/guardian of onset of hyperglycemia.
- If the student has symptoms of a hyperglycemia emergency, including 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: Call 911 (Emergency Medical Services) and the student’s parents/guardian.
- Contact student’s health care provider.

INSULIN THERAPY

Insulin delivery device: syringe insulin pen insulin pump

Type of insulin therapy at school:

- Adjustable Insulin Therapy
 Fixed Insulin Therapy
 No insulin

Adjustable Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:**

Name of insulin: _____

- **Carbohydrate Coverage:**

Insulin-to-Carbohydrate Ratio:

Lunch: 1 unit of insulin per _____ grams of carbohydrate

Snack: 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example

$$\frac{\text{Grams of carbohydrate in meal}}{\text{Insulin-to-carbohydrate ratio}} = \text{_____ units of insulin}$$

- **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____

Target blood glucose = _____ mg/dL

Correction Dose Calculation Example

$$\frac{\text{Actual Blood Glucose} - \text{Target Blood Glucose}}{\text{Blood Glucose Correction Factor/Insulin Sensitivity Factor}} = \text{_____ units of insulin}$$

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

INSULIN THERAPY (Continued)

When to give insulin:

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.

Other: _____

Correction dose only:

For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.

Other: _____

Fixed Insulin Therapy

Name of insulin: _____

_____ Units of insulin given pre-lunch daily

_____ Units of insulin given pre-snack daily

Other: _____

Parental Authorization to Adjust Insulin Dose:

Yes No Parents/guardian authorization should be obtained before administering a correction dose.

Yes No Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.

Yes No Parents/guardian 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/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

INSULIN THERAPY (Continued)

Student's self-care insulin administration skills:

- Yes No Independently calculates and gives own injections
 Yes No May calculate/give own injections with supervision
 Yes No Requires school nurse or trained diabetes personnel to calculate/give injections

ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP

Brand/Model of pump: _____ Type of insulin in pump: _____

Basal rates during school: _____

Type of infusion set: _____

- For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.
 For infusion site failure: Insert new infusion set and/or replace reservoir.
 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 No
Set a temporary basal rate Yes No _____% temporary basal for _____ hours
Suspend pump use Yes No

Student's self-care pump skills:

- Count carbohydrates
Bolus correct amount for carbohydrates consumed
Calculate and administer correction bolus
Calculate and set basal profiles
Calculate and set temporary basal rate
Change batteries
Disconnect pump
Reconnect pump to infusion set
Prepare reservoir and tubing
Insert infusion set
Troubleshoot alarms and malfunctions

Independent?

- Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 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/guardian discretion
 Student discretion

Student's self-care nutrition skills:

- Yes No Independently counts carbohydrates
 Yes No May count carbohydrates with supervision
 Yes No 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 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.

(Additional information for student on insulin pump is in the insulin section on page 6.)

DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.

- Continue to follow orders contained in this DMMP.
- Additional insulin orders as follows: _____
- Other: _____

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider 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:) _____'s 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 Date

Student's Parent/Guardian Date

School Nurse/Other Qualified Health Care Personnel Date

LaGrange Highlands School District 106

1750 W. Plainfield Road, LaGrange, IL 60525

Elementary School Health Office: (708) 485-3418

Middle School Health Office: (708) 485-3432

Elementary School Health Office Fax: (708) 485-3611

Middle School Health Office Fax: (708) 485-3593

School Year: _____

Grade and Teacher: _____

AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

(To Be Completed Annually by Physician)

Student Name: _____

Date of Birth: _____

This child is under my medical care for _____ and medication is required during the school day.

(Diagnosis)

Name of Drug	Dosage	Route	Frequency	Time To Be Given At School	Side Effects

This student has been instructed in the self-administration of the above epinephrine auto-injector (ONLY), knows the circumstances under which to use the medication, and may carry the auto-injector. _____

Prescriber's initials

Signature of Physician _____ Date _____ OFFICE STAMP

Printed Name of Physician _____ Physician's Office and Emergency Phone # _____

Asthma Inhalers - Parents please attach prescription label to the back of this form if student is self-administering.

My child has my permission to self-administer his/her asthma inhaler. _____ Parent's initials
By initialling here, the parent/guardian is responsible for the student carrying and maintaining their own inhaler

(To Be Completed By Parent or Legal Guardian)

I give permission for my child to receive the above medication(s) as directed by the physician. I will bring the medication to the school nurse in a container labeled by the pharmacy. I will provide a written doctor's order if the medication dosage is changed or the medication is discontinued. For all medications other than self-administered asthma medications or epinephrine auto-injectors, I understand that it is the responsibility of the student to report to the District 106 Health Office at the scheduled time to receive the medication. I further completely release and excuse LaGrange Highlands District 106 and its employees and agents of any liability or obligation of any nature in any way related to the District's medication policy and procedure.

"Self-administration" means that the student has the discretion as to the use of his/her asthma medication or epinephrine auto-injector (ONLY). Therefore, as the parent/guardian, I acknowledge that the student is responsible for having asthma medication or an epinephrine auto-injector available as needed, and that the student has demonstrated competency in the proper way to use the medication.

I, the parent/guardian of the above student acknowledge that, District 106, along with its employees and agents, incur no liability as a result of any injury arising from the student's self-administration of asthma medication or epinephrine auto-injector. I indemnify and hold harmless the district, along with its agents and employees, against any claims (except a claim based upon willful and wanton conduct).

Parent signature and date: _____ Telephone: _____

Emergency contact name: _____ Telephone: _____