

## 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):

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

**Treatment of low blood glucose (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):

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

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