FINAL DOCUMENT

Diabetes Medical Management Plan

Student Information Sheet

This plan should be completed by the student's parents/guardians and student's physician. It will be reviewed by the school nurse and shared with relevant school staff.

Pages 1&2 are to be completed by parent/guardian.

Student information

Student's name: _____ Student ID Number: __S_____

Date of Birth:_____Grade: _____ Homeroom teacher:_____

Date of diabetes diagnosis: _____ ☐ Type 1 ☐ Type 2 ☐ Other: _____

Other Health Conditions/Medical Diagnoses:_____

_____

Other diabetes medications bedsides insulin:

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

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

Student's physician/health care provider: _____

Address: _____

Telephone: _____ Emergency number: _____

Email address: _____

In case of immediate medical attention, I would prefer my student to be sent to:

Hospital Name:_____

Address:_____

Parent/Guardian Contact Information

NISD will reference the electronic database ESchool to contact caregivers. It is the responsibility of the parent/guardian to keep this information updated. If the parent/guardian is unable to make this change, he/she will notify the school nurse and school administration.

Below is to be completed by School Nurse:

Date of plan initiated: _____ This plan is valid for the calendar year: _____-_____

Date of plan received in clinic:_____

School nurse _____ Phone: _____

School: _____ School phone number: _____

Parent/Guardian Consent

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 Date

_____
_____

School Nurse/Other Qualified Health Care Personnel Date

Student Name:_____Date of birth:_____

Physician's Orders for Student Diabetic Management

Physician/Providers, please complete pages 3-6.
Pages 7-8 are to be completed if student is using a continuous glucose monitor.

Glucose Meter Information

Brand/model of blood glucose meter: _____

Target range of blood glucose:

Before meals: ☐ 90–130 mg/dL ☐ Other: _____

Check Blood Glucose Level Orders:

☐ 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

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 value

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.

Student Name:_____Date of birth:_____

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.
- Administer glucagon
- Name of glucagon used: _____

Injection:

Dose: •1mg •0.5mg •Other:_____

Route: •Subcutaneous(SC) •Intramuscular(IM)

Site: •Arms •Thighs •Buttocks •Other:_____

Nasal route:

Dose: •3mg

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

Route: • Intranasal Site: • Nose • Call 911 (Emergency Medical Services) and the student's parents/guardians. • Contact the student's health care provider. • If on insulin pump, stop by placing mode in suspend or disconnect. Always send pump with EMS to hospital	or shortness of breath, chest pain, increasing sleepiness or lethargy or depressed level of consciousness.

Student Name:_____Date of birth:_____

Insulin therapy orders

Type of insulin therapy at school: ☐ Adjustable (basal-bolus) insulin ☐ Fixed insulin therapy ☐ No insulin	**Adjustable (Basal-bolus) Insulin Therapy:** ▪ **Carbohydrate Coverage/Correction Dose** Name of insulin: _____ ▪ **Carbohydrate Coverage:** **Insulin-to-carbohydrate ratio:**
Insulin delivery device: ☐ Syringe ☐ Insulin pen ☐ Insulin pump	***Breakfast:*** ____ unit of insulin per _____ grams of carbohydrate ***Lunch:*** ____ unit of insulin per _____ grams of carbohydrate ***Snack:*** ____ unit of insulin per _____ grams of carbohydrate

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

When to give insulin		
Breakfast ☐ Carbohydrate coverage only ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____	**Lunch** ☐ Carbohydrate coverage only ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____	**Snack** ☐ No coverage for snack ☐ Carbohydrate coverage only ☐ Carbohydrate coverage plus correction dose when blood

mg/dL and _____ hours since last insulin dose. ☐ Other: _____	mg/dL and _____ hours since last insulin dose. ☐ Other: _____	glucose is greater than _____ mg/dL and _____ hours since last insulin dose. ☐ Other: _____

Fixed Insulin Therapy	**Basal 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: _____	Name of insulin: _____ To be given during school hours: ___ Pre-breakfast dose: ____ units ___ Pre-lunch dose: ____ units ___ Pre-dinner dose: ____ units

Student Name:_____Date of birth:_____

Insulin therapy orders (continued)

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.

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.

Disaster/Emergency and Drill Plan

To prepare for an unplanned disaster, emergency (72 hours) or drill, obtain emergency supply kit from parents/guardians. School nurse or other designated personnel should take student's diabetes supplies and medications to student's destination to make available to student for the duration of the unplanned disaster, emergency or drill.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follows (e.g., dinner and nighttime):

_____

_____

☐ Other: _____

Physician Signature

This Diabetes Medical Management Plan has been approved by:

_____

_____

Student's Physician/Health Care Provider Date

Student Name:_____Date of birth:_____

Continuous Glucose Monitor Orders

Brand/model: _____ **Type of insulin in pump**: _____

Type of infusion set: _____

Appropriate infusion site(s): _____

Alarms set for: Severe Low: _____ Low: _____ High: _____ Threshold suspend setting: _____ _____	Predictive alarm: Low: _____ High: _____ Rate of change: Low: _____ High: _____	• 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.

CGM may be used for insulin calculation if glucose is between ___-___ mg/dL ___Yes ___No

CGM may be used for hypoglycemia management ___ Yes ___ No

CGM may be used for hyperglycemia management ___ Yes ___ No

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:

_____

_____

Basal rates during school:	**Other pump instructions:**
Time: _____ Basal rate: _____ Time: _____ Basal rate: _____ Time: _____ Basal rate: _____	_____ _____ _____

☐ 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.

Student Name:_____Date of birth:_____

Continuous Glucose Monitor Orders

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

Meal/Snack	Time	Carbohydrate Content (grams)	Other Times	Carbohydrate Content (grams)
Breakfast		_____ to _____		
Mid-morning snack		_____ to _____		
Lunch		_____ to _____		
Mid-afternoon snack		_____ to _____		

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

☐ Parent/guardian substitution of food for meals, snacks and special events/parties permitted.

☐ Parents'/Guardians' discretion

☐ Student discretion

☐ Additional Instructions:_____

Student's self-care nutrition skills:

☐ Independently counts carbohydrates

☐ May count carbohydrates with supervision

☐ Requires school nurse/trained diabetes personnel to count carbohydrates

This form was developed by referencing the American Diabetes Association *Diabetes Medical Management Form*

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