# 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 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 Date

_____

Student's Parent/Guardian Date

_____

School Nurse/Other Qualified Health Care Personnel Date

# PROCEDURE FOR ADMINISTRATION OF MEDICATION

Prior to the School Nurses administering any medication, the health office shall have on file a **Medication Authorization Form** for the involved student, prepared by the student's attending licensed prescriber in compliance with the Manasquan School District's procedures, and signed by the student's parent/guardian.

Whenever possible, the parent/guardian should plan for medication to be administered at home, before and/or after school hours. In situations when a student's health could be compromised by not receiving medication during school hours, school district procedures must be followed for administering all medications.

1. Medication is defined as prescription or non-prescription (over the counter) drugs, including vitamins and supplements.

2. Administration of any medication requires both a physician's written order and signed parental permission.

3. Prescription medication must be in a pharmacy or physician labeled container. Over the counter medication must in its original container, sealed and unopened with the manufacturers label, clearly marked with the student's name.

4. It is the parent's/guardian's responsibility to bring the medication to school.

5. All medications to be taken during school hours will be kept in the School Nurse's office. It is the responsibility of the student to report to the nurse's office at the proper time to receive his/her medication. Students are allowed to carry and self-administer asthma medication or may use an Epinephrine Auto-Injector for anaphylaxis only after the school is notified, the student's parent/guardian and physician have signed the Medication Authorization Form, and it has been approved by our School Physician.

6. The parent/guardian must assume responsibility for informing the school, in writing, of any change in the student's health or change in medication. A physician's order must accompany any medication change.

7. Medication must be picked up by a parent/guardian on or before the last day of school. Medication not picked up will be discarded. Medication authorization is to be renewed, if necessary, every school year.

8. The school district cannot dispense medication without the completed Medication Authorization Form received, reviewed, and approved. It is wise to have it completed and mailed to the Office of the School Nurse in August for the upcoming school year.

**Please note: Any missing information on the Medication Authorization Form will render it incomplete and it will be returned to the parent/guardian for correction, which may delay implementation of a pharmacological treatment plan**

# MANASQUAN SCHOOL DISTRICT

## MEDICATION AUTHORIZATION FORM

Student's Name: _____ Date of Birth: _____

Grade: _____ Gender: _____ Home Address: _____

Parent/Guardian Name: _____ Contact #: _____

I (we) request authorization and consent to have the school nurse administer medication to my child, while in school, as prescribed by our private physician. The Manasquan BOE hereby informs the parents of the above child that the district shall not incur liability as a result of any injury from self-medication. I hereby sign that I have read the above statement and will hold the MBOE harmless against any injury or claims that arise as a result of my child's self-administration.

Signed _____ Date_____

## TO BE FILLED OUT BY PHYSICIAN

Diagnosis: _____Name of Medication: Insulin _____

Dosage, Form & Time: _____

If given prn, describe indications: _____ When can it be repeated? _____

Significant side effects include: _____

Is this medication for a life-threatening illness? _____ Is the child authorized to self- administer? ____

Has the child been trained by the healthcare provider? _____

Length of time this order is valid (may NOT exceed school year): _____

Physician's Signature: _____ Date: _____

Physician's Stamp:

## APPROVAL OF SCHOOL PHYSICIAN

I have reviewed the above request and authorize the school nurse to administer the prescribed medication as ordered during school hours.

School Physician's Signature _____ Date: _____

# MANASQUAN SCHOOL DISTRICT

## MEDICATION AUTHORIZATION FORM

Student's Name: _____ Date of Birth: _____

Grade: _____ Gender: _____ Home Address: _____

Parent/Guardian Name: _____ Contact #: _____

I (we) request authorization and consent to have the school nurse administer medication to my child, while in school, as prescribed by our private physician. The Manasquan BOE hereby informs the parents of the above child that the district shall not incur liability as a result of any injury from self-medication. I hereby sign that I have read the above statement and will hold the MBOE harmless against any injury or claims that arise as a result of my child's self-administration.

Signed _____ Date_____

## TO BE FILLED OUT BY PHYSICIAN

Diagnosis: _____Name of Medication: Glucagon _____

Dosage, Form & Time: _____

If given prn, describe indications: _____ When can it be repeated? _____

Significant side effects include: _____

Is this medication for a life-threatening illness? _____ Is the child authorized to self- administer? ____

Has the child been trained by the healthcare provider? _____

Length of time this order is valid (may NOT exceed school year): _____

Physician's Signature: _____ Date: _____

Physician's Stamp:

## APPROVAL OF SCHOOL PHYSICIAN

I have reviewed the above request and authorize the school nurse to administer the prescribed medication as ordered during school hours.

School Physician's Signature _____ Date: _____