



Diabetes Medical Management Plan/Treatment Authorization (DMMP)

School Year 20__ - 20__

Student's Name: _____ ID#: _____ Date of Birth: _____ Grade: _____

School Name: _____ WL# _____ School Contact Person: _____ Phone: _____

CONTACT INFORMATION:

Phone Numbers:

Parent/Guardian #1: _____ Home: _____ Work: _____ Cellular: _____

Parent/Guardian #2: _____ Home: _____ Work: _____ Cellular: _____

Physician/Healthcare Providers: _____ Phone #: _____

Other Emergency Contact: _____ Home: _____ Work: _____ Cellular: _____

EMERGENCY NOTIFICATION: Notify parent/guardian of the following conditions:

(If unable to reach parent/guardian, call the healthcare provider and emergency contact listed above.)

- a. Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.
- b. Blood sugars in excess of _____ mg/dL
- c. Positive urine ketones.
- d. Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, slurred speech, or altered level of consciousness.

MEALS/SNACKS: Student can: Determine correct portions and number of carbohydrate/serving. Calculate carbohydrate grams accurately.

	<u>Time/Location</u>	<u>Food Content and Amount</u>		<u>Time/Location</u>	<u>Food Content and Amount</u>
<input type="checkbox"/> Breakfast	_____	_____	<input type="checkbox"/> Mid-afternoon	_____	_____
<input type="checkbox"/> Midmorning	_____	_____	<input type="checkbox"/> Before PE/Activity	_____	_____
<input type="checkbox"/> Lunch	_____	_____	<input type="checkbox"/> After PE/Activity	_____	_____

If outside food for party or food sampling provided to class: _____

Date of Diagnosis: _____; Diabetes Type 1 Type 2

BLOOD GLUCOSE MONITORING AT SCHOOL: Yes No Type of Meter: _____

If yes, can student: Ordinarily perform own blood glucose checks? Yes No Interpret results? Yes No

Needs supervision? Yes No; If yes, describe the supervision needed: __Glucose checks __Interpret results __Disposal of strips/sharps
__ Other: _____

Student has been trained in blood glucose monitoring: Yes No **Student is authorized to carry glucometer:** Yes No

Time to be performed: Before breakfast Before PE/Activity Time After PE/Activity Time
 Mid-morning (before snack) Mid-Afternoon
 Before lunch _____ hours after meals
 Dismissal As needed for signs/symptoms of low/high blood glucose

Place to be performed: Classroom Clinic/Health Room Other: _____

Target Range for blood glucose: _____ mg/dL to _____ mg/dL (optional)

INSULIN DURING SCHOOL: Yes No Parent/guardian elects to give insulin needed at school.

If yes, can student: Determine correct dose? Yes No Draw up correct dose? Yes No Give own injection? Yes No

Needs supervision? Yes No; If yes, describe the supervision needed: __Insulin calculation __Insulin administration __Disposal of sharps
__ Other: _____

Student has been trained in the use of insulin: Yes No **Student is authorized to carry and self-administer insulin:** Yes No

Student's Name: _____ ID#: _____ Date: _____

Diabetes Medical Management Plan/Treatment Authorization *(Continued)*

INSULIN DELIVERY: Syringe/Vial Pen Pump; *Complete ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP section, pg 3.*

STANDARD DAILY INSULIN AT SCHOOL: Yes No

Type: _____ Dose: _____ Time to be given: _____

Calculate insulin dose for carbohydrate intake: Yes No

If yes use: ___ Humalog ___ Novolog ___ Other: _____

_____ # unit(s) per _____ grams carbohydrate

Add carbohydrate dose to correction of insulin dose: (Time) _____

Comments: _____

Correction Dose of Insulin for High Blood Glucose:

Yes No; **If yes:** ___ Humalog ___ Novolog

___ Other: _____ Time to be given: _____

DETERMINE DOSE PER SLIDING SCALE BELOW:

Blood Sugar	Insulin Dose
_____ - _____	_____
_____ - _____	_____
_____ - _____	_____
_____ - _____	_____
_____ - _____	_____

EXERCISE, SPORTS, AND FIELD TRIPS: Blood glucose monitoring and snacks as stated on page 1.

Quick access to: Sugar-free liquids, fast-acting carbohydrates, snacks, and monitoring equipment.

A fast-acting carbohydrate such as _____ should be available at the site.

Child should not exercise if blood glucose level is below _____ mg/dL OR if _____

MANAGEMENT OF HIGH BLOOD GLUCOSE (Over _____ mg/dL)

Usual signs/symptoms for this student:

- Increased thirst, urination, appetite
- Tired/drowsy
- Blurred vision
- Warm, dry, or flushed skin
- Frequent bathroom privileges

Indicate treatment choices:

- Sugar-free fluids as tolerated
- Check urine ketones if blood glucose over _____ mg/dL
- Notify parent if urine ketones positive.
- Nausea/Vomiting
- Other: _____

Refer to **INSULIN DELIVERY** section: "Correction Dose of Insulin for High Blood Glucose"

Other: _____

MANAGEMENT OF LOW BLOOD GLUCOSE (Below _____ mg/dL)

Usual signs/symptoms for this student:

- Change in personality/behavior
- Pallor
- Weak/shaky/tremulous
- Tired/drowsy/fatigued
- Dizzy/staggering walk
- Headache
- Rapid heartbeat
- Nausea/loss of appetite
- Clammy/sweating
- Blurred vision
- Inattention/confusion
- Slurred speech
- Loss of consciousness
- Seizures
- Other: _____

Indicate treatment choices:

If student is awake and able to swallow, give _____ grams fast-acting carbohydrate such as:

- 4oz. Fruit juice or non-diet soda *or*
- 3-4 Glucose tablets *or*
- Concentrated gel or tube frosting *or*
- 8 oz. (Skim) Milk *or*
- Other: _____

Retest Blood Glucose **10-15 minutes** after treatment.

Repeat treatment until Blood Glucose over _____ mg/dL.

Follow treatment with snack of _____ if more than 1 hour till next meal/snack or if going to activity (e.g., PE/Recess).

___ Other: _____

IMPORTANT!! *If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements):*

Call 911 immediately and notify parents/guardian *and give:*

___ Glucagon ½ mg or 1 mg dose should be given by trained personnel. Route: SC IM

Site for glucagon injection: arm thigh Other: _____

___ Glucose gel 1 tube can be administered inside cheek and massaged from outside while waiting for help to arrive, or during administration of Glucagon by any trained staff member at scene.

Student should be turned on his/her side and maintained in this "recovery" position till fully awake.

Student's Name: _____ ID#: _____ Date: _____

Diabetes Medical Management Plan/Treatment Authorization *(Continued)*

OTHER ROUTINE DIABETES MEDICATIONS AT SCHOOL: Yes No; If yes, include name of medication, dose, time, route, and possible side effects: _____

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/guardians.
- 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: Independent?

- | | |
|---|--|
| Count carbohydrates | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bolus correct amount for carbohydrates consumed | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Calculate and administer correction bolus | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Calculate and set basal profiles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Calculate and set temporary basal rate | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Change batteries | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Student's self-care pump skills: Independent?

- | | |
|--------------------------------------|--|
| Disconnect pump | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reconnect pump to infusion set | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prepare reservoir and tubing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Insert infusion set | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Troubleshoot alarms and malfunctions | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PHYSICIAN AUTHORIZATION: I am aware that this medication may be administered by school personnel/non-medical staff.

Physician's Name (PLEASE PRINT/STAMP)

Signature

Date

Address: _____

Telephone: _____

PARENT/GUARDIAN PERMISSION: I understand that:

- This Diabetes Medical Management Plan/Treatment Authorization (DMMP) form is valid for this school year only and must be renewed each school year.
- Any changes in the medication, dosage, or frequency of treatment will require a new DMMP form to be completed.
- Medications/equipment must be in original container and labeled to match physician's order for school use.
- The parent is responsible for providing medication(s) and supplies as needed.
- The parent will utilize the posted lunch menu to guide meal planning and carbohydrate counting with child.

I grant the principal or his/her designee or a licensed nurse (RN/LPN) permission to assist with or perform the administration of each prescribed medication, including insulin either by injection or pump, and treatments/procedures for my child during the school day. This includes when he/she is away from school property for official school events. I have reviewed, understand and agree with the medications/treatments prescribed by the physician/healthcare provider on this form. It is my responsibility to notify the school if there is a change in the medication/treatment plan prior to its expiration date.

Parent/Guardian Signature: _____

Date: _____

SCHOOL NURSE/OTHER QUALIFIED HEALTH CARE PERSONNEL:

Note: Nonmedical assistive personnel shall be allowed to perform health-related services upon successful completion of child-specific training by a registered nurse (FL Statute 1006.062(4) and School Board rule 6GX13-5D-1.021).

Acknowledged and received by: _____

Date: _____

Student's Name: _____

ID#: _____

Date: _____