St. Lucie Public Schools

Diabetes Medical Management Plan (DMMP) (School Year ____ - ____)

Student Name _____ **DOB** _____ Diabetes Type 1 ___ Type 2 ___ other___

Any known allergies (food or drug)_____

CHECKING BLOOD GLUCOSE

Check blood glucose level: ( ) before lunch ( ) __hours after lunch ( ) ___ hours after a correction dose ( ) mid morning ( ) before PE ( ) after PE ( ) before dismissal ( ) other _____ ( ) as needed for signs/symptoms of high or low glucose levels ( ) as needed for signs/symptoms of illness

Location of glucose monitoring: ( ) classroom ( ) clinic ( ) other _____

Students self care skills ( ) Independently checks own blood glucose ( ) May check blood glucose with supervision ( ) Requires trained personnel to check blood glucose

Continuous blood glucose monitor (CGM) ( ) yes ( ) no Brand/ model_____ Alarms set for ( ) high ( ) low

Note: Always confirm CGM results with blood glucose meter before taking action

INSULIN THERAPY

Student Self Care Insulin Skills

( ) Independently calculates and gives own injections ( ) Requires trained personnel to calculate / administer insulin ( ) May calculate/ give own injection with supervision

When to give insulin:

( ) Lunch: **( ) Breakfast** ( ) carbohydrate coverage only ( ) carbohydrate coverage plus *correction dose when blood glucose is greater than ___ mg/dl and ___ hours since last insulin dose ( ) fixed dose ( ) other _____

( ) Snacks: ( ) 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.

Note: Correction dose may require deduction of insulin from carbohydrate coverage if blood glucose is less than target ( ) yes ( ) No

Insulin type: ( ) Regular ( ) Humalog ( ) Novolog ( ) Apidra

Delivery system: ( ) pen ( ) syringe ( ) pump

( ) Correction dose formula: Blood glucose minus _____ divided by _____ = Insulin dose	( ) Carbohydrate to insulin ratio: 1 unit per _____ grams of carbohydrate
( ) Correction dose sliding scale: Blood glucose: _____ Insulin dose _____ Blood glucose: _____ Insulin dose _____ Blood glucose: _____ Insulin dose _____ Blood glucose: _____ Insulin dose _____ Blood glucose: _____ Insulin dose _____ Blood glucose: _____ Insulin dose _____	( ) Fixed standard daily dose at school: Type: _____ Dose: ____ Time: _____ Type: _____ Dose: ____ Time :_____

OTHER ROUTINE DIABETES MEDICATIONS AT SCHOOL

Medication Name _____ Dose _____ Route _____ Time _____

MEAL PLAN

(Meal times are approximate due to school schedule issues)

Meal/ Snack	**Time** (if known)	**Carbohydrate Content (grams)**
Breakfast	_____	_____ to _____
Mid morning snack	_____	_____ to _____
Lunch	_____	_____ to _____
Mid afternoon snack	_____	_____ to _____

Activity snacks: ___grams of carbohydrates ( ) before ( ) every 30 minutes during ( ) after strenuous activity

Other: _____If blood glucose is less than ___mg/dl before exercise (PE) give ____grams of carbohydrate

MD Initials _____

Instructions for when food is provided to class (e.g., as part of a class party or food sampling event) _____
_____
Special event/ party food permitted: ( ) Parental discretion ( ) Student discretion
Student's self-care nutrition skills: ( ) Independently counts carbohydrates ( ) May count carbohydrates with supervision
( ) Requires trained diabetes personnel to count carbohydrates

STUDENT WITH INSULIN PUMP

Brand/ Model of pump: _____ Type of insulin in pump_____
Basal rates in school _____ ( ) For blood glucose greater than ___ mg / dl that has not decreased within ___ hours after correction, consider **pump or infusion site failure** and notify parents.
( ) For suspected pump/ site failure, suspend or remove pump and give insulin by syringe or pen.
( ) May disconnect for sports or exercise.
( ) May suspend for sports or exercise.

Student's self- care pumps skills:

( ) Independent:	**Needs Supervision:**
Giving boluses of insulin for both correction of blood glucose target and for food consumption	( ) yes ( ) no
Changing of insulin infusion sets	( ) yes ( ) no
Switching to injections should there be a problem	( ) yes ( ) no

( ) Non-Independent: Child lock on? ( ) yes ( ) no
Insulin for meals and snacks will be given as follows: _____
Parents will be notified for pump/ infusion site malfunction. Infusion site changes will be done by parent.

HYPERGLYCEMIA TREATMENT (High Blood Glucose greater than _____)

Student's usual symptoms of hyperglycemia are _____
( ) For blood glucose greater than____ mg/dl AND at least ____ hours since last insulin dose, give correction dose of insulin (see orders on page 1). If student wears a pump, recheck blood glucose ____ hours after correction dose.
( ) For blood glucose greater than ____ mg/ dl, check ( ) urine ( ) blood ketones.
Notify parents if ketones are moderate- large or symptoms present.
Notify parents if: _____
Give extra drinking water. Avoid exercise if blood glucose greater than ____ mg/dl or ketones moderate- large
If student has symptoms of hyperglycemia crisis, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing lethargy or sleepiness, or depressed level of consciousness: call 911 and the parents.

HYPOGLYCEMIA TREATMENT (Low Blood Glucose less than _____)

Student's usual symptoms are_____
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. ( ) For blood glucose less than 50 mg/dl give 30 grams of carbohydrate. ( ) Recheck blood glucose in 10 -15 minutes and repeat treatment if blood glucose is less than ___ mg /dl.
( ) If pre lunch blood glucose between ___ and ___, send immediately to lunch room and then recheck blood glucose after lunch.
Call parents if blood glucose is less than ____ mg/dl after 2 attempts to treat.
( ) Follow treatment with a snack of complex carbohydrate/protein unless going to lunch within 10-15 minutes.
Student should not exercise unless blood glucose is greater than ____mg/ dl.
If student is unable to eat or drink, is unconscious or unresponsive, or is having a seizure (jerking movements) call 911 and give: Glucagon ( ) 1 mg ( ) ½ mg SC or IM
( ) Glucose gel 1 tube can be administered inside the cheek and massage from outside while awaiting or during administration of Glucagon. ( ) If glucagon is administered to student with insulin pump, suspend or disconnect pump.

MD Initials _____

Student Name _____ **DOB** _____

EXERCISE AND SPORTS

Easy access to water, fast acting carbohydrates and glucose monitoring equipment recommended.
Also refer to meals, hypo and hyperglycemia treatment (see page 2)

DISASTER PLAN AND OVERNIGHT FIELD TRIPS

To prepare for an unplanned disaster or emergency (72 hours) obtain emergency supply kit from parent.
( ) Continue to follow orders contained in this DMMP
( ) Additional insulin orders as follows: _____
( ) Other: _____

PARENTAL AUTHORIZATION TO ADJUST INSULIN

( ) Parent authorization should be obtained before administering a correction dose.
( ) Parents are authorized to increase or decrease correction dose scale within the following range: +/- ____ units of insulin
( ) Parents are authorized to increase or decrease insulin to carbohydrate ratio within the following range: 1 unit per prescribed grams of carbohydrate, +/- _____grams of carbohydrates.
( ) Parents are authorized to increase or decrease fixed insulin dose within the following range: +/- ___units of insulin

CONSENTS

I understand that all treatments and procedures may be performed by the student and/ or unlicensed assistive personnel within the school or by EMS in the event of loss of consciousness or seizure. I have reviewed this information sheet and agree with the indicated instructions. This form will assist the nurse in developing a health care plan.

SIGNATURES

_____ _____ _____
Physician (Print name and signature) Office Phone # Date

***I agree to provide all medications and supplies to allow school to provide care as indicated in the DMMP.**
***I understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures.**
***I have reviewed this information sheet and agree with the indicated instructions.**
***I give permission for the school nurse to share information with appropriate school staff relevant to the prescribed treatment plan as he/ she determines appropriate for my child's health and safety.**
***I give permission for the school health nurse to contact my child's physician relevant to the DMMP as he/she determines appropriate for my child's health and safety.**
***I give permission for my child to receive medication during school hours administered by the nurse or trained designee.**

_____ _____
Parent (Print name and signature) Phone # Date

_____ _____
Principal / School Name Date

_____ _____
School nurse (Print and signature) Phone # Date

_____ _____
Trained designee Date

MD Initials _____