Clear Form

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.

	Time/Location	Food Content and Amount		Time/Location	Food Content and Amount
☐ **Breakfast**			☐ **Mid-afternoon**		
☐ **Midmorning**			☐ **Before PE/Activity**		
☐ **Lunch**			☐ **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
__ Mid-morning (before snack)
__ Before lunch
__ Dismissal
__ Before PE/Activity Time __ After PE/Activity Time
__ Mid-Afternoon
__ _____ hours after meals
__ 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: _____

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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	☐Yes ☐No
Bolus correct amount for carbohydrates consumed	☐Yes ☐No
Calculate and administer correction bolus	☐Yes ☐No
Calculate and set basal profiles	☐Yes ☐No
Calculate and set temporary basal rate	☐Yes ☐No
Change batteries	☐Yes ☐No

Student's self-care pump skills:	**Independent?**
Disconnect pump	☐Yes ☐No
Reconnect pump to infusion set	☐Yes ☐No
Prepare reservoir and tubing	☐Yes ☐No
Insert infusion set	☐Yes ☐No
Troubleshoot alarms and malfunctions	☐Yes ☐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 Statue 1006.062(4) and School Board rule 6GX13-5D-1.021).

Acknowledged and received by: _____ **Date:**_____

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