**DIABETES MEDICAL MANAGEMENT PLAN (DMMP)**

**School Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BLOOD GLUCOSE (BG) MONITORING:** (Treat BG below 80mg/dl or above 150 mg/dl as outlined below.)

🗆 Before meals 🗆 as needed for suspected low/high BG 🗆 2 hours after correction 🗆Dismissal 🗆Mid-afternoon

**INSULIN ADMINISTRATION:** Dose determined by: 🗆 Student 🗆Parent 🗆 School nurse or Trained Diabetes Personnel

 Insulin delivery system: 🗆 Syringe 🗆Pen 🗆Pump

MEAL INSULIN: (It is best if given right **before eating**. For small children, can give within 15-30 minutes of the first bite of food or right after meal.)

Insulin Type: 🗆 Humalog 🗆 Novolog 🗆 Apidra

* Insulin to Carbohydrate Ratio: \_\_\_\_\_\_\_ unit per \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ grams carbohydrate
* Set Doses: Give \_\_\_\_\_\_ units (Eat \_\_\_\_\_\_\_\_\_\_ grams carbohydrates)

CORRECTION INSULIN: (For high blood sugar. Add before meal insulin to correction/sliding scale insulin for total meal time insulin dose.)

🗆 Use the following correction formula

 (for pre-lunch blood sugar over 150):

(BG – 100) ÷ \_\_\_\_\_ = extra units insulin to provide

🗆 Sliding Scale: BG from \_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ u

 BG from \_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ u

 BG from \_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ u

 BG from \_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ u

***MILD low sugar****: Alert and cooperative student*

*(BG below 80)*

* Never leave student alone
* Give 15 grams glucose; recheck in 15 minutes
* Notify parent if not resolved
* If no meal is scheduled in the next hour, provide an additional snack with carbohydrate, fat, protein.
* If BG remains below 70, retreat and recheck in 15 minutes

***SEVERE low sugar****: Loss of consciousness or seizure*

* Call 911. Open airway. Turn to side.

Glucagon injection 🗆0.25 mg 🗆0.50 mg 🗆1.0 mg IM/SQ

* Notify parent.
* For students using insulin pump, stop pump by placing in “suspend” or stop mode/disconnecting at pigtail or clip and removing an attached pump. If pump was removed, send with EMS to hospital.

***MANAGEMENT OF HIGH BLOOD GLUCOSE (above 150 mg/dl)***

* Sugar-free fluids/frequent bathroom privileges.
* If BG is greater than 300, and it’s been 2 hours since last dose, give HALF FULL correction formula noted above.
* If BG is greater than 300, and it’s been 4 hours since last dose, give FULL correction formula noted above.
* If BG is greater than 300, check for ketones. Notify parent if ketones are present.
* Note and document changes in status.
* Child should be allowed to stay in school unless vomiting and moderate or large ketones are present.

**MANAGEMENT DURING PHYSICAL ACTIVITY:**

Student shall have easy access to fast-acting carbohydrates, snacks, and blood glucose monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below 80 mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

* Check blood sugar right before physical education to determine need for additional snack.
* If BG is less than 80 mg/dl, eat 15-45 grams carbohydrates before, depending on intensity and length of exercise.
* Student may disconnect insulin pump for 1 hour or decrease basal rate by \_\_\_\_\_\_\_\_.
* At the beginning of a new activity check blood sugar and after exercise only until a pattern for management is established.
* A snack is required prior to participation in physical education.

**MEAL PLAN:**

* A snack will be provided each day at: \_\_\_\_\_\_\_\_\_\_
* If regularly scheduled meal plan is disrupted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**SPECIAL MANAGEMENT OF INSULIN PUMP**: Applicable to student? 🗆 Yes 🗆 No (If yes, select options below)

* Contact Parent in event of: \* pump alarms or malfunctions \* detachment of dressing/infusion set out of place \*Leakage of insulin \* Student must give insulin injection \* Student has to change site \* Soreness or redness at site \* Corrective measures do not return blood glucose to target range within \_\_\_\_ hours
* Parents will provide extra supplies including infusion sets, reservoirs, batteries, pump insulin, and syringes.

**This student requires assistance by the School Nurse or Trained Diabetes Personnel with the following aspects of diabetes management:**

* Monitor and record blood glucose levels
* Respond to elevated or low blood glucose levels in the designated clinic office
* Administer glucagon when required
* Administer insulin or oral medication
* Monitor blood or urine ketones
* Follow instructions regarding meals and snacks
* Follow instructions as related to physical activity
* Insulin pump management: administer insulin, inspect infusion site, contact parents for problems
* Provide other specified assistance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This student may independently perform the following aspects of diabetes management:**

Monitor blood glucose:

* in the classroom
* in any area of the school and at any school
* related activity
* Monitor urine or blood ketones
* Administer insulin
* Treat hypoglycemia (low blood sugar)
* Treat hyperglycemia (elevated blood sugar)
* Carry supplies for blood glucose monitoring
* Carry supplies for insulin administration
* Determine own snack/meal content
* Manage insulin pump
* Replace insulin pump infusion set

**LOCATION OF SUPPLIES EQUIPMENT**: (To be completed by school personnel and parent. Parent to provide and restock snacks and low blood sugar supplies box.)

 Clinic Room With Student Clinic Room With Student

Blood glucose equipment 🗆 🗆 Glucagon kit 🗆 🗆

Insulin administration supplies 🗆 🗆 Glucose gel 🗆 🗆

Ketone supplies 🗆 🗆 Juice/low blood glucose snacks 🗆 🗆

**EMERGENCY NOTIFICATION**: Notify parents of the following conditions:

a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon

b. Blood sugars in excess of 300 mg/dl, when ketones present

c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURES:** I understand that all treatments and procedures may be performed by the student and/or Trained Diabetes Personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child’s diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by the Georgia state law.

PARENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SCHOOL NURSE SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My signature provides authorization for the above Diabetes Medical Management Plan. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

* Dose/treatment changes may be relayed through parent
* Student is due for medical appointment for review of diabetes management plan.

HEALTHCARE PROVIDER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diabetic Emergency Care Plan**

School Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_ Date of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Emergency Contact Information**Mother/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Care Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Trained Diabetes Personnel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Hyperglycemia**

**Diabetes – Hyperglycemia Emergency Care Plan (For High Blood Glucose)**

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| **Causes of Hyperglycemia**  | **Onset of Hyperglycemia**  |
| * + Too little insulin or other glucose-lowering medication
	+ Food intake that has not been covered adequately by insulin
	+ Decreased physical activity
	+ Illness
	+ Infection
	+ Injury
	+ Severe physical or emotional stress
	+ Pump malfunction
 | * Over several hours or days
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| **Hyperglycemia Signs**  | **Hyperglycemia Emergency Symptoms** (Diabetic Ketoacidosis, DKA, which is associated with hyperglycemia, ketosis, and dehydration)  |
| **Circle student’s usual signs and symptoms.** |
| * Increased thirst and/or dry mouth
* Frequent or increased urination
* Change in appetite and nausea
* Blurry vision
* Fatigue
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Dry mouth, extreme thirst, and dehydration
* Nausea and vomiting
* Severe abdominal pain
* Fruity breath
* Heavy breathing or shortness of breath
* Chest pain
* Increasing sleepiness or lethargy
* Depressed level of consciousness
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| **Actions for Treating Hyperglycemia** |
| **Notify School Nurse or Trained Diabetes Personnel as soon as you observe symptoms.** |
| **Treatment for Hyperglycemia**  | **Treatment for Hyperglycemia Emergency**  |
| * Check the blood glucose level: \_\_\_\_\_\_\_\_\_ mg/dL.
* Check urine or blood for ketones if blood glucose levels are greater than: \_\_\_\_\_\_\_ mg/dL.
* If student uses a pump, check to see if pump is connected properly and functioning.
* Administer supplemental insulin dose: \_\_\_\_\_\_\_\_\_\_.
* Give extra water or non-sugar-containing drinks (not fruit juices): \_\_\_\_\_\_\_\_\_\_\_ ounces per hour
* Allow free and unrestricted access to the restroom.
* Recheck block glucose every 2 hours to determine if decreasing to target range of \_\_\_\_\_\_\_ mg/dL.
* Restrict participation in physical activity if blood glucose is greater than \_\_\_\_\_\_\_ mg/dL and if ketones are moderate to large.
* Notify parents/guardian if ketones are present.
 | * Call parents/guardian, student’s health care provider, and 911 (Emergency Medical Services) right away.
* Stay with the student until Emergency Medical Services arrive.
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**Hypoglycemia**

**Diabetes – Hypoglycemia Emergency Care Plan (For Low Blood Glucose)**

**THE STUDENT SHOULD NEVER BE LEFT ALONE, OR SENT ANYWHERE ALONE, OR WITH ANOTHER STUDENT, WHEN EXPERIENCING HYPOGLYCEMIA.**

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| **Causes of Hypoglycemia**  | **Onset of Hypoglycemia** |
| * Too much insulin
* Missing or delaying meals or snacks
* Not eating enough food (carbohydrates)
* Giving extra, intense, or unplanned physical activity
* Being ill, particularly with gastrointestinal illness
 | * Sudden – symptoms may progress rapidly
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| **Hypoglycemia Symptoms****Circle student’s usual symptoms.** |
| **Mild to Moderate** | **Severe** |
| * Shaky or jittery
* Sweaty
* Hungry
* Pale
* Headache
* Blurry vision
* Sleepy
 | * Dizzy
* Confused
* Disoriented
* Uncoordinated
* Irritable or nervous
* Argumentative
 |  * Combative
* Changed personality
* Changed behavior
* Inability to concentrate
* Weak
* Lethargic
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Inability to eat or drink
* Unconscious
* Unresponsive
* Seizure activity or convulsions (jerking movements)
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| **Actions for Treating Hypoglycemia** |
| Notify School Nurse or Trained Diabetes Personnel as soon as you observe symptoms.If possible, check blood glucose (sugar) at fingertip.Treat for hypoglycemia if glucose level is less than \_\_\_\_\_\_ mg/dL.**WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.** |
| **Treatment for Mild to Moderate Hypoglycemia** | **Treatment for Severe Hypoglycemia** |
| * Provide quick-acting glucose (sugar) product equal to \_\_\_\_\_\_\_ grams of carbohydrates. Examples of 15 grams of carbohydrates include:
* 3 or 4 glucose tablets
* 1 tube of glucose gel
* 4 ounces of fruit juice (not low-calorie or reduced sugar)
* 6 ounces of soda (1/2 can)(not low-calorie or reduced sugar)
* Wait 10 to 15 minutes.
* Recheck blood glucose level.
* Repeat quick-acting glucose product if blood glucose level is less than \_\_\_\_\_\_\_ mg/dL.
* Contact the student’s parents/guardian.
 | * Position the student on his or her side.
* Do not attempt to give anything by mouth.
* Administer glucagon: \_\_\_\_\_\_\_ mg at \_\_\_\_\_\_\_\_\_\_ site.
* While treating, have another person call 911 (Emergency Medical Services)
* Contact the student’s parents/guardian.
* Stay with the student until Emergency Medical Services arrive.
* Notify student’s health care provider
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