Jefferson Joint School District #251

DIABETES Medical Management Plan (DMMP)

With Diabetes Emergency Care Plan (DECP)

(For District Use) Effective Date: _____

Student Name: _____ DOB: _____ School: _____

Age at diagnosis: _____ ❒ Type 1 ❒ Type 2 Grade: _____

Diabetes Medication and Supplies will be kept:

❒ Student Carries ❒ Backpack ❒ Classroom ❒ Office ❒ Other:_____

BLOOD GLUCOSE TESTING:

Target range for blood glucose (BG): ❒ 100-200 ❒ 80-150 ❒ Other: _____

Time to test: ❒ Before Meals ❒ Before Exercise ❒ After Exercise ❒ Before Going Home ❒ If Symptomatic
❒ Other: _____

Contact Parent/Guardian if:

❒ Blood Glucose level is less than _____mg/dL or more than _____mg/dL

❒ Urine/Blood ketones are moderate to large

CONTINUOUS GLUCOSE MONITORING (CGM):

❒ This student uses a **Continuous Glucose Monitor (CGM**)
CGM Manufacturer/Model: _____

❒ The CGM is FDA approved for insulin dosing based on glucose values, and the Parent/Guardian approves the school personnel or school nurse to dose from the CGM.

❒ Re-check blood glucose level by finger prick if CGM value is less than _____mg/dL or more than _____ mg/dL.
Or if:_____

❒ CGM readings are for trends only. **ALWAYS** verify with blood glucose before any dosing.

❒ This student uses a smart phone or other monitoring technology to track blood glucose values.
Please specify: _____

INSULIN PRESCRIBING INFORMATION:

Insulin Name:
❒ Humalog
❒ Apidra
❒ Novolog
❒ Other: _____

Method of Administration:
❒ Insulin vial/syringe
❒ Insulin Pen
❒ Insulin Pump (Product Name):_____

Purpose: Lower blood glucose level
Route: Subcutaneous

Possible Side Effects:
Hypoglycemia

I:C Ratio (Insulin to Carbohydrate Ratio):
Breakfast: 1 unit for every _____ grams of carbohydrate.
Lunch: 1 unit for every _____ grams of carbohydrate.
Snack: 1 unit for every _____ grams of carbohydrate.

Correction Dose: Administer _____ unit(s) insulin for every _____ mg/dl above blood glucose level _____ mg/dL.

(Correction Dose can only be administered at mealtimes unless on a pump. See pump orders below.)

Independence Level:

❒ Independently calculates and gives own injections.

❒ May calculate/administer own injections with supervision.

❒ Requires school nurse or trained office staff to calculate dose and student can administer injections with supervision.

❒ Requires school nurse or trained staff to calculate dose and administer injections.

Insulin Pump Orders (if applicable):

- If using insulin pump, carbohydrate ratio and correction dose are calculated by pump.
- Correction doses at times other than meals to be done per PUMP calculation ONLY.

❒ For blood glucose greater than _____mg/dL that has not decreased within _____ hour(s) after correction, consider pump or infusion site failure. Notify parent/guardian.

❒ Other Instructions: _____.

HYPOglycemia Treatment (low blood glucose level):

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL:

- Give 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.
- Student should NOT go home on the bus if blood glucose level is less than _____ mg/dL.

Additional treatment: _____

Severe HYPOglycemia Treatment (low blood glucose level): EMERGENCY MEDICATION ADMINISTRATION

Administer Immediately for Symptoms:

Unable to eat or drink, unconscious, unresponsive, unable to control airway, seizing or convulsions (jerking movements), other _____

- Turn student on his/her side to prevent choking
- Administer Emergency Medication
- Call 911 (Emergency Medical Services)
- Contact the student's parents/guardians

Emergency Medication Dosing Instructions

Medication Name: _____

Dose: ❒ 0.5 mg injection ❒ 1.0 mg injection
❒ 3 mg intranasal ❒ 0.6 mg/0.6 mL prefilled
❒ other _____ autoinjector

Administration Site:
❒ Thigh ❒ Buttocks ❒ Upper Arm ❒ Nasal Cavity
❒ Other: _____

Purpose of Medication: Elevate blood glucose level
Possible Side Effects: Nausea and Vomiting

HYPERglycemia Treatment (High Blood Glucose Level):

If exhibiting symptoms of hyperglycemia, OR if blood glucose level is above _____ mg/dL:

- Provide extra water or non-sugar containing fluids (not fruit juices): _____ ounces per hour.
- Allow unrestricted access to restrooms.
- Follow Physical Activity guidelines.
- If on a pump, follow Insulin Pump guidelines.
- Additional treatment: _____

KETONES:

Check: ❒ Urine ❒ Blood for Ketones every _____ hour(s) when blood glucose level is above _____ mg/dL.

If Ketones present are Moderate to Large, **call parent/guardian for immediate pick up**.

ACCOMMODATIONS AND PRECAUTIONS

Academic testing: ❒ Student may reschedule any academic testing with teacher, as needed, if blood glucose is below _____mg/dl or over _____mg/dl.

Lunch, student will typically eat: ❒ School Lunch
❒ Home Lunch (parent must provide carb counts)

PE:
❒ If BG is below _____, treat hypoglycemia first with **quick-acting carb**, wait 15 minutes, recheck.
❒ If BG is _____ to _____, give _____ grams of **non-quick-acting carbs** (do not give insulin for these carbs).
❒ If BG is _____ to 299, OK to exercise.
❒ If BG is 300 or higher, check for ketones. If moderate or large ketones, **DO NOT exercise**, call parent/guardian for immediate pick up and provide non-sugar containing fluids if student is able to swallow.
❒ Student may be disconnected from pump for a maximum of _____ minutes for PE.
❒ Other: _____

Snacks/School Parties: ❒ No coverage for snacks at parties ❒ Use Insulin to Carbohydrate (I:C) Ratio
❒ Parent will provide alternate snack ❒ Student to take snack home
❒ Other (specify): _____

Field Trips: All Diabetes Medication (including Glucagon), Insulin, Testing Supplies, Snacks, Water, and at least one Diabetes Trained Personnel must accompany student on all field trips.
❒ Other: _____

Additional Information:

- Student must always be allowed access to fast-acting sugar, water, and unrestricted bathroom privileges.
- Student is allowed to test his/her blood glucose when/where needed.
- Substitute teachers **must** be aware of student's health situation, but still respect privacy.
- Other Considerations or Precautions: _____

* A new DMMP with included Medication Prescription Information and Licensed Independent Provider and Parent/Guardian Signatures is required annually.
* In accordance with these orders, an Emergency Care Plan (ECP) must be developed by the School Nurse, Student, and Parent/Guardian to be shared with appropriate school personnel and cannot be shared with any individual outside of those public education employees without parental consent.

TO BE COMPLETED BY PARENT/GUARDIAN:

As Parent/Guardian of the named student:

* I understand the information contained in this plan will be shared with school staff on a need-to-know basis.
* I give permission to the District Nurse and other designated staff to follow this Emergency Care Plan and administer medication/insulin as directed.
* I understand that a school team, including the parent/guardian, may make decisions about implementation and assistance in the school based on consideration of the above recommendation, available resources, and the student's level of self-management.
* I agree to indemnify, defend, and hold the School District harmless from any and all claims, actions, cost, expenses, damages, and liabilities, including attorney's fees, arising out of, connected with, or resulting from the administration of medication.
* I agree that the School District, Board of Education, Board of Education Employees, and its Agents shall incur no liability as a result of any injury arising out of or connected with the administration of medication.
* I agree I will not institute either on our own behalf or behalf of the pupil, any claim or action against the Board of Education, Board of Education employees and its agents arising out of or connected with administration of medication.
* I understand this agreement must be signed and in full effect prior to the administration of medication.
* I understand I am responsible for maintaining necessary testing supplies, medication/insulin, snacks, and equipment.
* My child and I understand there are serious consequences for sharing any medication with others.
* I understand School Authorities will notify Parent/Guardian at the end of the school year to pick up medication. Medication which is not repossessed by the Parent/Guardian within a seven-day period of notification by school authorities will be destroyed by the School Nurse in the presence of a witness.
* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order.
* I understand that if any emergency medication is administered at school, EMS will be notified for student evaluation, monitoring, and possible further treatment, and he/she may not remain at school.

_____ (____)_____

Parent/Guardian Name (please print) Best Contact Phone Number

_____ _____

Parent/Guardian Signature Date

PARENT/GUARDIAN TO SIGN – Authorization for Exchange of Confidential Student Information

I authorize my child's **Health Care Provider (Name)** _____ to exchange confidential health information with the District Nurse(s) for the completion of this plan of care and to exchange Health information and records for not more than 12 months after the date of signature.

Parent/Guardian Signature _____ **Date**_____

By signing authorization, I understand that the parties named above are permitted to exchange written and verbal information regarding my child. The parties may also accept a photocopy of this release form and give it the same full force and effect as the original. I further understand that I may revoke this authorization in writing at any time by providing a copy of my revocation to the parties named above. The information used or disclosed under this release might be disclosed by the school district as an educational record, pursuant to FERPA and might no longer be protected by HIPAA.

TO BE COMPLETED BY PHYSICIAN:

Student Independence Level: As the student's Licensed Independent Provider (LIP), I confirm the student has a diagnosis of diabetes mellitus; and per my assessment, I recommend:

❒ This student is capable to carbohydrate count meals and snacks for insulin adjustment, carry, and self-administer diabetes medication/insulin.

❒ This student requires a trained adult to supervise carbohydrate counting of meals and snacks for insulin adjustment and self-administration of diabetes medication/insulin.

❒ This student requires a trained adult to carbohydrate count meals and snacks, for insulin calculation, and to administer diabetes medication/insulin during periods the student is under the care of the school.

Parents/Guardians Authorization to Adjust Insulin Dose:

❒ Parents/Guardians are authorized to increase OR decrease correction dose scale within the following range: +/- _____ units of insulin.

❒ Parents/Guardians are authorized to increase OR decrease insulin-to-carbohydrate ratio within the following range: one unit of prescribed insulin per +/- ____ grams of carbohydrate.

❒ Parents/Guardians are authorized to increase OR decrease fixed insulin dose within the following range: +/- ____ units of insulin.

_____ (____)_____

Licensed Independent Provider (LIP) Name (please print) Phone Number

_____ _____

LIP Signature Date

Jefferson Joint School District #251
DIABETES – Emergency Care Plan

(For District Use) Effective Date:

Student Name: _____ DOB: _____ School:_____

Parent/Guardian: _____ Phone: _____ Grade:_____

Student is fine when blood glucose is within the Target Range -- _____ mg/dL and _____ mg/dL

Notify Parent/Guardian when blood glucose is below _____ mg/dL or above _____ mg/dL.

Always test if student is showing signs/symptoms of high or low blood glucose!
Emergency situations may occur with low blood glucose!!

HYPOglycemia - Low Blood Glucose

Mild/Moderate Symptoms: Please Circle

Anxiety	Blurry Vision	Sweating
Confusion	Crying	Dizziness
Hunger	Slurred Speech	Irritability
Paleness	Minor Headache	Shakiness
Drowsiness/Tired	Weakness	
Poor Concentration	Poor Coordination	
Personality Change	Sudden Behavior Change	

Other: _____

- ❒ Student needs treatment when blood glucose level is below ____ mg/dL or if symptomatic.
- ❒ If treated outside the classroom, a responsible person **MUST** accompany the student to the office. **Do NOT send anywhere ALONE**
- ❒ If blood glucose is below _____ mg/dL, give 15 grams of fast acting sugar source, for example: 3-4 glucose tablets, 4 ounces juice, **OR** one packet fruit snacks.
- ❒ Wait 15 minutes & recheck blood glucose.
- ❒ Repeat until blood glucose is above ____ mg/dL
- ❒ Disconnect or suspend pump.

SEVERE Symptoms: Please Circle

Combative	Inability to eat	Unconscious
Unresponsive	Seizures	

Other: _____

- ❒ Position on side. **Do not** give anything by mouth.
- ❒ Contact trained diabetes personnel.
- ❒ **Administer Emergency Medication. Call 911!**
- ❒ Contact Parents/Guardians.
- ❒ **STAY WITH STUDENT** until EMS arrives.

Emergency Medication Administration:

Person to give Emergency Medication: ❒ School Nurse ❒ Parent ❒ EMS ❒ Trained Office Staff

(Specify):_____

Name of Emergency Medication: _____

Location of Emergency Medication:_____

Nasal: ❒ 3.0 mg

Prefilled Autoinjector: ❒ 0.6 mg/0.6 mL Site:_____

Injection: ❒ 0.5 mg ❒ 1.0 mg Site:_____

HYPERglycemia - High Blood Glucose

Mild/Moderate Symptoms: Please Circle

Behavior Change	Blurry Vision
Fatigue/Sleepiness	Frequent Urination
Major Headache	Stomach Ache
Thirst/Dry Mouth	

Other: _____

- ❒ Student needs treatment when blood glucose level is above ____ mg/dL or if symptomatic.
- ❒ Encourage student to drink water or sugar-free drinks.
- ❒ Allow unrestricted bathroom privileges.
- ❒ Administer correction dose of insulin if on pump.
- ❒ Recheck blood glucose level in _____ hr(s).

SEVERE Symptoms: Please Circle

Blurred Vision	Chest Pain
Increased Hunger	Nausea/Vomiting
Sweet Fruity Breath	Severe Abdominal Pains
Decreased Consciousness	
Breathing Changes (Kussmaul Breathing)	

Other: _____

- ❒ Administer correction dose of insulin if on pump.
- ❒ Encourage student to drink water.
- ❒ Call Parent/Guardian.
- ❒ **Call 911** if student has breathing changes or decreased consciousness.
- ❒ **STAY WITH STUDENT** until EMS arrives.

If vomiting, call parent/guardian **IMMEDIATELY!**