Diabetes Medical Management Plan (DMMP)

Note

Students who have diabetes are generally under the care of a pediatric endocrinologist. These specialists will provide authorization for diabetic medical management for their patients while at school. The Parent Consent and Health-Care Authorization form provided in this section is one example of an educational Diabetic Medical Management Plan (DMMP). Many pediatric endocrinologists use standard educational plans specific to their practice and are adapted to meet the needs of their patients.

PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of DIABETES in Educational Settings and Sponsored Events (DMMP)

Student:	DOB:	Date:
District/Site:	**Teacher/Rm:**	**Grade:**

1. **Latex Allergy:** ☐ Yes ☐ No
2. **GLUCOSE MONITORING:**
   ☐ Yes ☐ No Student routinely checks glucose prior to insulin administration:
   ☐ before meals ☐ before snacks ☐ before boarding bus ☐ all suspected hypoglycemia
   Student may check glucose as needed throughout the day**:** ☐ Yes ☐ No
   Student has CGM**:** ☐ Yes ☐ No Brand: ____
3. **INSULIN DOSING:**
   Type of insulin: ____
   Delivery: ☐ Pump ☐ Pen ☐ Syringe ☐ Other: ____ ☐ Follow insulin dose per pump
   Mealtime insulin to be given: ☐ Pre-meal ☐ Post-meal ☐ Either

Breakfast	Lunch	Dinner/After School Meal
Insulin dose = ____ units Insulin dose = ____ units/ ____ grams of carbs	Insulin dose = ____ units Insulin dose = ____ units/ ____ grams of carbs	Insulin dose = ____ units Insulin dose = ____ units/ ____ grams of carbs

Sliding Scale: (**DO NOT USE IF WITHIN 3 HOURS OF PREVIOUS INSULIN DOSE**)

____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL
____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL
____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL
____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL
____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL
____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL
____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL	____ units if BG is ____ to ____ mg/dL
Sliding scale is based on correction factor of ____ units/ ____ mg/dL BG greater than ____ mg/dL	Sliding scale is based on correction factor of ____ units/ ____ mg/dL BG greater than ____ mg/dL	Sliding scale is based on correction factor of ____ units/ ____ mg/dL BG greater than ____ mg/dL

4. **Mark all that Apply**:
   ☐ Use this dose if insulin is used to cover snacks: Insulin dose = ____ units/ ____ grams of carbs
   ☐ Do not use insulin to cover snacks.
   ☐ OK to use CGM reading to dose insulin (if symptoms do not match CGM reading, check blood glucose).
   ☐ All decisions are made on a BLOOD GLUCOSE level regardless of CGM reading.
   ☐ Use a blood glucose reading rather than CGM, when treating hypoglycemia.
   ☐ Licensed Credentialed School Nurse may decrease total insulin dosage by (+/-) 1 unit.
5. **Student's LEVEL OF INDEPENDENCE**:

Student can perform own blood glucose checks.	☐ No	☐ With Supervision	☐ Yes
Student can calculate carbs independently.	☐ No	☐ With Supervision	☐ Yes
Student can determine correct amount of insulin.	☐ No	☐ With Supervision	☐ Yes
Student can draw correct dose of insulin.	☐ No	☐ With Supervision	☐ Yes
Student can give own injections.	☐ No	☐ With Supervision	☐ Yes
Student can bolus correctly (for carbs or correction of hyperglycemia).	☐ No	☐ With Supervision	☐ Yes
Student can troubleshoot alarms and malfunctions on pump.	☐ No	☐ With Supervision	☐ Yes
Student may carry own supplies (i.e., pen/glucometer).	☐ No	☐ With Supervision	☐ Yes
Student uses a (CGM) and requires access to smart device(s).	☐ No	☐ With Supervision	☐ Yes

PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of DIABETES in Educational Settings and Sponsored Events (DMMP)

6. **HYPOGLYCEMIA (Low Blood Glucose)**

If conscious and able to swallow:

- If blood glucose is < ____ mg/dL, give 15 grams of carbs and recheck blood glucose in 15 minutes.
- Repeat until blood glucose is > ____ mg/dL

If unable to swallow, seizing, or unconscious, give Glucagon.

- If Glucagon is indicated, administer it simultaneously while calling 9-1-1 and the parent/guardians.
- Glucagon dosage: ____
- Type: ☐ Vial with syringe ☐ Nasal powder ☐ Pre-filled syringe ☐ Auto-injector

*Never send student home alone with a LOW blood sugar.

7. **HYPERGLYCEMIA (High Blood Glucose)**

☐ Check urine ketones if blood glucose > 350 mg/dL

☐ Give insulin per order (For student on injections: **DO NOT GIVE IF WITHIN 3 HOURS OF PREVIOUS CORRECTION DOSE.** For student on pump: follow pump's direction for dose.)

IF KETONES are MODERATE or LARGE and student has symptoms, student to be sent home.

☐ Do not send student home alone with a high blood glucose.

Contact parent if blood glucose is above ____ mg/dL.

8. **Guidelines for Physical Education and/or Exercise**

- If blood glucose is below ____ mg/dL, student to correct for low blood glucose; must be in the target range before participation. See above for hypoglycemia treatment.
- If blood glucose is between 80-120 mg/kL before exercise, provide 15 grams of carbs and allow student to participate.
- If student's blood glucose is above 350 mg/dL, they should not participate in strenuous activity. Treat as indicated above.
- Students with a pump may disconnect pump for up to ____ hour(s) for exercise**:** ☐ Yes ☐ No

Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations.

_____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

***Authorized Health-Care Provider Name** _____ ***NPI Number** _____

Signature _____ **Date**_____

Phone _____ **Address** _____ **City** _____ **Zip** _____

Supervising Physician Name _____ **NPI Number** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

☐ I request that the credentialed school nurse provide me with a copy of the completed Individualized Health-Care Plan (IHP).

Parent Consent for Authorization and Management in the Educational Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.

I (we) will:

1. provide the necessary supplies and equipment;
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized health-care provider when necessary.

I (we) understand that I (we) will be provided a copy of my child's completed Individualized Health-Care Plan (IHP).

Parent(s)/Guardian(s) Signature: _____ **Date** _____

_____ **Date** _____

Reviewed by credentialed school nurse (signature) _____ **Date** _____

☐ **Credentialed school nurse has informed principal about health-care services provided for this student.**