Student Name: **School Year:**

Diabetes Medication Management Orders (DMMO) Plan

For use with: Choose an item. **&** Choose an item.

TARGET GLUCOSE RANGE IS Choose an item. - Choose an item. **mg/dl**

Student & Contact Information		School Name:
Student Name:	Diabetes: ☐Type 1 ☐Type 2	School Phone:
DOB:	Grade in school: Choose an item.	School Fax:

Parent/Guardian Information		
Parent Name:	Phone:	Email:
Parent Name:	Phone:	Email:
Emergency Contact:	Phone:	Relationship:

Endocrinologist		
Name: Joshua Smith, MD	Phone: 208-523-1122 Option 4	Fax: 208-523-2582

School nurse or Allowed Trained Staff **must list 2 people*	
Name:	Phone:
Name:	Phone:

Blood Glucose Testing/Monitoring

Blood Glucose Testing/Monitoring Independence Level: Choose an item.

Times to test:

☐ Before lunch ☐ Before/after PE ☐ Before going home ☐ If (Choose an item.) stops working contact parent, use fingerstick

☐ If symptoms don't match (Choose an item.) call parents ☐ Okay to test via fingerstick if symptoms don't match (Choose an item.)

Call parent if blood glucose is below Choose an item. **mg/dl (after treating low blood glucose 15 minutes)**

or above Choose an item. **mg/dl (if already given a correction and it hasn't come down for 2 hrs).**

***** Always check if showing signs/ symptoms of low or high blood glucose*****

Insulin Delivery

Location of Medication: ______________________

****Unopened/unused insulin can be stored in refrigerator until expiration date. Once used, expires in 28 days.*

Insulin Independence Level: Choose an item.

Person(s) to administer insulin: ___________________________

Time of day insulin should be administered:

☐ 10 min before breakfast ☐ 10 min before lunch ☐ 10 min before snacks (unless low, then no insulin)

☐ If a correction is needed ☐ Other times: ____

Type of insulin: Choose an ite.

Method of insulin delivery:

Primary: Choose an item.

Secondary: ☐ None at this time Other: ☐______________ **Contact parent if there is any problem with method of delivery*

Blood Glucose Correction Dose (Bolus): Correction should be administered via Primary method of delivery as recommended by: ☐ The pump ☐ Insulin dosing sheet (See attached pg)	**Meal Bolus: Insulin-Carbohydrate:** Bolus should be administered via Primary method of delivery as recommended by: ☐ The pump ☐ Insulin dosing sheet (see attached pg)
Carbohydrate Counting Independence level:	

Snacks

Are snacks needed during school? ☐ As needed for low blood sugar (Snacks provided by parent)
☐Other times snacks are needed: ____
Directions for class snacks (i.e. birthday treats… etc):

Exercise and Sports

Pump should be in activity mode during exercise: ☐ Yes ☐ No

If blood sugar is less than Choose an item. or arrow indicates that student is low or will be low a snack needed before PE/recess to bring blood sugars up.

Student should not exercise if blood glucose sensor level is below Choose an item. mg/dl (unless trending upward).

If blood glucose is over 300 on 2 checks 1 hour apart or with symptoms of illness/vomiting the school should:
☐ Contact parent, provide water, and wait for parent instruction.
☐ Check ketones and if ketones are present, call parents, provide water and student should not exercise.
- Student may need insulin via injection. Do you want the school to do this for your student? Choose an item.

Low Blood Glucose (Hypoglycemia)

COMMON SYMPTOMS:

☐ Shaky	☐ Sweating	☐ Weakness
☐ Fast Heartbeat	☐ Blurry Vision	☐ Dizzy
☐ Fatigue	☐ Anxious	☐ Headache
☐ Irritable	☐ Confusion	☐ Hungry

Other symptoms: ____________

Emergency situations may occur with low blood sugar

Student needs treatment when blood glucose is below Choose an item. mg/dl or if symptomatic

- If treated outside the classroom, a responsible person MUST accompany student to the office.
- After 15 minutes recheck blood sugar.
- Repeat until sensor glucose is over Choose an item. mg/dl or trending up at a good rate.

Use of Glucagon — *Glucagon Name:* Choose an item.

Symptoms:

- Student is unable to orally ingest fast acting carbohydrates
- Student is unconscious
- Student is non responsive

- **IMMEDIATELY** contact delegated staff member to administer glucagon!
- **IMMEDIATELY** contact 911
- **IMMEDIATELY** contact parents

High Blood Glucose (Hyperglycemia)

COMMON SYMPTOMS:		WHAT TO DO:
☐ Extreme Thirst	☐ Frequent Urination	• Student needs treatment when blood glucose is over Choose an item. mg/dl and no active insulin.
☐ Hyper	☐ Dry Skin	• If Fast acting insulin has been administered and blood sugar is over Choose an item. mg/dl for over 2 hours contact parent.
☐ Hungry	☐ Achy	• Allow unrestricted bathroom privileges.
☐ Grumpy	☐ Slow Wound Healing	• Encourage student to drink water or sugar-free drinks.
☐ Headache		• If vomiting or diarrhea call parent ***immediately!***
Other symptoms:___ ___________________________		

Additional Accommodations

- Student must always be allowed access to, including during testing, fast-acting sugar, meter, mobile phone, wifi access, water bottle, unrestricted bathroom privileges, and drink privileges.
- Student is not allowed to exercise alone without supervision.
- Substitute teachers must be aware of the student's health situation, but still respecting privacy.
- Notify parent(s)/guardian when blood sugar is below Choose an item. mg/dl (after treating low blood glucose) or above Choose an item. mg/dl for over 2 hours after having given a correction and for emergencies.

PUMP INFORMATION AND MALFUNCTIONS

- If any problems noticed with the pump, notify parent immediately.
- If pod, cartridge, or infusion sets needs to be changed: Choose an item.
- Settings are not to be altered except by Parent, Doctor, or Diabetes Educator.
- Do not override the pump.
- Please do not silence phone or PDM due to risk of missing important notifications/alerts.

Additional Instructions

Parents/Authorized Person as designated in the school plan may make adjustments to these instructions. All dosage changes will be approved by parent, authorized person or emergency contact persons listed in the school plan before being given.

As parent/guardian of the above named student, I give my permission to the school nurse and other designated approved staff to perform and carry out the diabetes tasks as outlined in this Individualized Health Plan (IHP) and for my child's healthcare provider to share information with the school nurse for the completion of this plan.

I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/ Authorized Persons to notify the school nurses whenever there is any change in the student's health status or care. Parents/ Authorized Persons and student are responsible for maintaining necessary supplies, snack, blood glucose monitor, medications and equipment.

Parent Signature____Date___________________________

Parent Signature____Date___________________________________

Physician Signature____Date___________________________________