**Student Name: _____ School Year: _____**

# Diabetes Medication Management Orders (DMMO) Plan

**For use with:** ☐insulin pump ☐insulin pen & ☐CGM ☐Glucose meter (fingerstick)

**Name of medical devices used: _____**

TARGET GLUCOSE RANGE IS ____ -_____ **mg/dl**

| Student & Contact Information | | School Name: |
|---|---|---|
| Student Name: | Diabetes: ☐Type 1 ☐Type 2 | School phone: |
| DOB: | Grade in school: | School Fax: |

| Parent/Guardian Information | | |
|---|---|---|
| Parent name: | Phone: | Email: |
| Parent name: | Phone: | Email: |
| Emergency Contact: | Phone: | Relationship to student: |

| 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:**

☐ Student needs assistance and can NOT monitor blood sugars independently
☐ Student needs supervision monitoring blood sugars
☐ Student can monitor blood sugars independently

**Times to test:**

☐ Before eating ☐ Before/after PE ☐ Before going home ☐ If CGM :_____ stops working, use fingerstick

☐ Other times to test:

_____

**Call parent if blood glucose is below _____ mg/dl (after treating low blood glucose 15 minutes) or above _____ 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:**

☐ Student needs assistance and can NOT self-administer insulin
☐ Student needs supervision when administering insulin
☐ Student can administer insulin independently

**Person (s) to administer insulin: _____**

**Time of day insulin should be administered:**

☐ 10 min before eating ☐ If a correction is needed ☐ Other times: _____
☐ If student is low before eating, call parent to discuss meal time dosing

**Type of insulin:** ☐ Humalog ☐ Humalog Jr ☐ Novolog ☐ Lispro ☐ Aspart ☐ Lyumjev ☐ Fiasp

**Method of insulin delivery:**
Primary: ☐ T-slimX2 ☐ Omnipod Dash ☐ Omnipod 5 ☐ iLet pump ☐ Medtronic 780 ☐ Insulin pen
Secondary: ☐ None at this time Other: ☐_____ **Contact parent if there is any problem with method of delivery*

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

**Carbohydrate counting Independence level:**
☐ Student needs assistance and can NOT count carbs themselves
☐ Student needs supervision when counting carbs
☐ Student can count carbs independently

## Snacks

☐ As needed for low blood sugar *(snacks provided by parent)* ☐ Other times snacks are needed: _____
Directions for class snacks: _____

## Exercise and Sports

Pump should be in activity mode during exercise: ☐ Yes ☐ No ☐ N/A Student is NOT currently using a pump

If blood sugar is less than _____ 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 _____ 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*

## 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 _____ 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 _____ mg/dl or trending up at a good rate.

## *Use of Glucagon* — *Glucagon Name:* ☐ Baqsimi (nasal) ☐ Gvoke ☐ Zegalogue

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 ____ mg/dl and no active insulin. |
| ☐ Hyper | ☐ Headache | • If fast acting insulin has been administered and blood sugar is over_____ mg/dl for over 2 hours contact parent. |
| ☐ Hungry | ☐ Achy | • Allow unrestricted bathroom privileges. |
| ☐ Grumpy | ☐ Flushed | • Encourage student to drink water or sugar-free drinks. |
| Other symptoms: _____ | | • If vomiting or diarrhea call parent ***immediately!*** |

## 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.
- 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 _____ mg/dl (after treating low blood glucose) or above _____ mg/dl for over 2 hours after having given a correction and for emergencies.

## PUMP INFORMATION AND MALFUNCTIONS

☐ N/A- Student is NOT currently using a pump

- If any problems noticed with the pump, notify parent immediately.
- If pod or infusion sets needs to be changed: _____
- 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_____