

AMERICAN LEADERSHIP ACADEMY

Diabetic Medical Management Plan (DMMP)

This plan should be completed by the student's personal health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be easily accessed by the school nurse or other trained diabetes personnel. It is the parent/guardian's responsibility to update any changes in the student's plan.

Date of Plan: _____ (This plan will be valid for one year)

Campus: _____

Student's Information

Student's Name: _____ Date of Birth: _____ Grade: _____

Date of Diagnosis: _____ Type 1 Type 2 Other: _____

Parent/Guardian Name: _____ Phone Number(s): _____

Emergency Contact: _____ Phone Number: _____

Relationship to student: _____

Health Care Provider Information

Provider Name: _____ Phone Number: _____

Address: _____

This Diabetes Medical Management Plan has been completed and/or approved by:

Provider Signature: _____ **Date:** _____

(Please read all the way to the end and initial on page 6 as appropriate)

Medication and Equipment

Medication: _____ Dose: _____ Route: _____ Time/Frequency: _____

Medication: _____ Dose: _____ Route: _____ Time/Frequency: _____

Medication: _____ Dose: _____ Route: _____ Time/Frequency: _____

Continuous Glucose Monitor (CGM): Yes No Used for Dosing: Yes No

Brand/Model: _____ Student uses independently: Yes No

Glucose Meter: Yes No Brand/Model: _____ Student uses independently: Yes No

Pump: Yes No Brand/Model: _____ Student uses independently: Yes No

Basal rate: Yes No *If yes:* ____ : ____ - ____ : ____ Basal Rate: _____

____ : ____ - ____ : ____ Basal Rate: _____

Type of Infusion set: _____ Appropriate Sites: _____

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Blood Glucose Monitoring

Target Range of Blood Glucose: _____ - _____

Check Blood Glucose:

- Before Breakfast After Breakfast
 Before Lunch After Lunch
 Before PE After PE As needed for signs/symptoms of illness
 2 hours after a correction dose As needed for signs/symptoms of low or high blood glucose
 Other: _____

Student's Checking Skills (*Check One*)

	Independently checks own blood glucose
	Supervised checks of own blood glucose
	Staff to perform blood glucose checks

Student should be escorted to the Health Office if blood sugar is:

Less than: _____ or Greater than: _____

Continuous Glucose Monitor (CGM)

Alarms set for: Severe Low: _____ Low: _____ High: _____

Predictive Alarm: Low: _____ High: _____ Rate Change/Suspend: Low: _____ High: _____

- Confirm CGM results with a hard stick before giving insulin (*unless student is approved for dosing off CGM-Dexcom G6 ONLY at this time*)
- If student has signs/symptoms of hypoglycemia, check fingertip glucose regardless of CGM.
- Insulin injections should be given at least three inches away from the CGM site.
- Do not disconnect the CGM for any reason
- If the adhesive is peeling, reinforce it with approved medical tape
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw away any pieces.

Student CGM Skills	Independently	
	Yes	No
Troubleshoots alarms and malfunctions		
Knows how to respond to a HIGH alarm		
Knows how to respond to a LOW alarm		
Can Calibrate the CGM		
Knows how to respond to blood glucose trend indications		
Changes CGM site		

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Insulin Therapy

Main Insulin Delivery Type: Pump Pen Syringe

Secondary(backup) Insulin Delivery Type: Pen Syringe Location: _____

Bolus Insulin Therapy

Name of Fast-acting Insulin to be used at school: _____

When to give Insulin (check all that apply):

Breakfast

- Carbohydrate coverage only
- Carbohydrate coverage plus Correction dose when blood glucose is greater than _____ and at least _____ hours since last insulin dose.

Lunch

- Carbohydrate coverage only
- Carbohydrate coverage plus Correction dose when blood glucose is greater than _____ and at least _____ hours since last insulin dose.

Snack

- Carbohydrate coverage only
- Carbohydrate coverage plus Correction dose when blood glucose is greater than _____ and at least _____ hours since last insulin dose.

Other:

- Correction Dose only Details: _____

Carbohydrate Coverage	Correction Dose
<p>Insulin-to-Carbohydrate Ratio:</p> <p>Breakfast: 1 unit of insulin per _____ grams of carbs</p> <p>Lunch: 1 unit of insulin per _____ grams of carbs</p> <p>Snack: 1 unit of insulin per _____ grams of carbs</p>	<p>Correction Factor (Insulin Sensitivity Factor): _____</p> <p>Target Blood Glucose (BG): _____</p>
<p>Calculation:</p> <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 2px;">Total grams of Carbohydrate eaten</div> <div style="margin: 0 10px;">=</div> <div style="border: 1px solid black; padding: 2px;">Units of Insulin</div> </div> <p style="text-align: center; margin-top: 5px;">Insulin-to-Carbohydrate Ratio</p>	<p>Calculation:</p> <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 2px;">Current BG – Target BG</div> <div style="margin: 0 10px;">=</div> <div style="border: 1px solid black; padding: 2px;">Units of Insulin</div> </div> <p style="text-align: center; margin-top: 5px;">Correction Factor</p>

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Insulin Therapy (cont.)

Call parents if:

- BS is less than _____
- BS is greater than _____
- Suspected or actual pump failure

Student's Insulin Administration Skills (Check One)

<input type="checkbox"/>	Independently calculates and gives own injections
<input type="checkbox"/>	Supervised calculations and injections
<input type="checkbox"/>	Staff to calculate dose and student to give own injection
<input type="checkbox"/>	Staff to calculate dose and student to give injection with supervision
<input type="checkbox"/>	Staff to calculate dose and give injection

Pumps

For blood glucose greater than _____ that has not decrease within _____ hours after correction, consider pump failure.

For infusion site/pump failure, give insulin via secondary method as described on page 3

Student may disconnect pump for: Physical Activity Other: _____ for no more than _____ hours

Student Pump Skills	Independently	
	Yes	No
Administers correct bolus		
0Sets or adjusts basal rates		
Changes batteries		
Disconnects pump		
Reconnects pump to infusion set		
Prepares reservoir, pod and/or tubing		
Inserts infusion set		
Troubleshoots alarms and malfunctions		

Nutrition

Student will eat breakfast at school and will require correction dose

Special party/event food may be provided to the class at times, student may have this food at the:

Students discretion Parent/Guardian's discretion Student may not partake

Physical Activity

The following quick acting glucose must be available at the site of physical education activities and sports

Glucose tablets Sugar containing juice Other: _____

Student should eat 15grams 30grams Other: _____grams of carbohydrate

Before every 30 minutes during Every 60 minutes during After vigorous physical activity

If most recent blood glucose is less than _____, student can participate in physical activity when blood glucose is corrected and above _____.

Avoid physical activity when blood glucose is greater than _____ or if urine/blood ketones are moderate to large.

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Hypoglycemia (Low Blood Glucose) Treatment

Student's usual symptoms of hypoglycemia:

- Hunger Sweating Trembling Pale Skin Inability to Concentrate Confusion
 Irritability Sleepiness Headache Dizziness Slurred Speech Poor Coordination
 Other: _____

If exhibiting any of these symptoms, OR if blood glucose level is less than _____, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose is less than _____.

Additional Treatment: _____

If the student is unable to eat or drink, is unconscious or unresponsive, or having seizure activity or convulsions:

- Position the student on his or her side to prevent choking
 - Do not attempt to put anything in their mouth
 - Do not hold them down or restrict movement when seizing
 - Give Glucagon: 1mg 0.5mg Other dose: _____
 Subcutaneous (SQ) Intramuscular (IM)
- Preferred site: Buttocks Arm Thigh Other: _____
- Call 911 and then the student's parents/guardians

Do not leave student alone or allow to leave class alone if their blood glucose is less than _____

Hyperglycemia (High Blood Glucose) Treatment

Student's usual symptoms of hypoglycemia:

- Extreme/Excessive Thirst Sleepiness Inability to Concentrate Blurred Vision
 Frequent Urination Headache Nausea Vomiting Confusion
 Other: _____

Ketones:

Check via: Urine Blood every _____ hours when blood glucose is greater than _____.

Additional Treatment for Ketones: _____

✦ Allow unrestricted access to the bathroom and water

If the student has symptoms of a hyperglycemia emergency, call 911 and contact the student's parents/guardians. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing fatigue or lethargy and/or decreased level of consciousness.

**Encourage
Fluids!**

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Disaster Plan

- To prepare for an unplanned disaster or emergency, parents/guardians will provide a 72-hour emergency supply kit
- Continue to follow orders contained in this DMMP
- Additional orders as follows (ex. Dinner and nighttime): _____
- Other: _____

To Be completed by the Medical Provider:

The parents/guardians are authorized to adjust as follows (check all that apply):

- Increase or Decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate *Initials:* _____
- Increase or Decrease correction dose scale within the following range: +/- _____ units of insulin *Initials:* _____
- Parents/guardians may NOT make adjustments without a providers order *Initials:* _____

We are requesting use of ALA's Internet (Wi-Fi) to enable us to utilize a continuous monitoring device that monitor's my child's blood sugar levels. We have read and agree with the following statement:

ALA has not and cannot guarantee that its Internet will always be operational during the school day or at any other times that your student may be present on the school campus. By checking the box above, you agree not to use ALA's Internet for any purpose other than to monitor blood sugar and/or other health related status or needs. While using ALA's Internet the student should not assume any privacy as all internet content is logged and monitored. The student and family agree to follow the policies of the school, and abide by all local, state, and federal laws. You understand you have the option to purchase a phone or other device for your student that will support a data plan and therefore not require reliance upon ALA's Internet. You agree to ALA's IT department handling your student's device for the purpose of enabling Wi-Fi services. Wi-Fi will be disabled at the end of the school year, use of this service must be elected annually on your students DMMP.

Signatures

I (parent/guardian) _____, give permission to the school Health Aide or another qualified health care professional or trained diabetes personnel of American Leadership Academy to perform and carry out the diabetes care tasks as outlined in (student) _____'s Diabetes Medical Management Plan (DMMP). I also consent to the release of the information contained in this DMMP to all school staff members and other adults who have a responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the Health Aide or another qualified health care professional to contact my child's physician/healthcare provider to verify and obtain information.

Acknowledged and received by:

Student's Parent/Guardian

Date

Student's Parent/Guardian

Date

Health Aide/ District Nurse

Date

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Daily Schedule

	Evaluation	Action
Event:	Less than:	Call parents/guardians Never leave alone Give _____ grams of fast acting sugar
	—	
	—	
Time:	Greater than:	Call parents/guardians Encourage water or other non-sugary fluids
Event:	Less than:	Call parents/guardians Never leave alone Give _____ grams of fast acting sugar
Lunch	—	
	—	
Time:	Greater than:	Call parents/guardians Encourage water or other non-sugary fluids
Event:	Less than:	Call parents/guardians Never leave alone Give _____ grams of fast acting sugar
Snack	—	
	—	
Time:	Greater than:	Call parents/guardians Encourage water or other non-sugary fluids
Event:	Less than:	Call parents/guardians Never leave alone Give _____ grams of fast acting sugar
<input type="checkbox"/> PE	—	
<input type="checkbox"/> Other:	-	
Time:	Greater than:	Call parents/guardians Encourage water or other non-sugary fluids

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Letter to Parent Regarding Administration of Medication in School

Dear Parent:

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type, including over the counter drugs given during school hours, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form *Request for Medication Administration in School* from the school nurse or school secretary. Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed by the physician for all prescription drugs and naturopathic remedies, the form must be signed by the doctor and by you, the parent or guardian. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over the counter drugs must be received in the original container, labeled with your child's name, and will be administered according to the written instructions on the label.
(Please read initial and sign page 2, Parent/Guardian responsibilities)
3. You may discuss with your doctor an alternative schedule for administering medication (i.e. outside of school hours)
4. Self-Medication: Students requiring medication for asthma, anaphylactic reactions (or both), and diabetes may self-medicate with physician authorization, parent permission and a student agreement for self-carried medication. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for and management of self-carry medications.
5. School personnel will not administer any prescription medication or naturopathic remedy to a student unless the school has received a completed *Request for Medication Administration in School* form that has been signed by both doctor and parent/guardian, and the medication has been received in an appropriately labeled container. If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school nurse

Thank you for your cooperation,

School Nurse

Date

Director

Date

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The Responsibility of the Parent or Legal Guardian

1. _____ Limit the medications that must be given during the school day to those necessary in order to maintain the child at school.
2. _____ Parents may choose to administer the medication at school themselves.
3. _____ Medication must be delivered to the Health Office **by the parent or other responsible delegated adult**.
4. _____ Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form *Request for Medication Administration in School* form. Return completed form to school.
5. _____ A separate parent request/permission form must be completed for each medication given at school.
6. _____ The *Request for Medication Administration in School* form must be signed by a health care provider licensed to prescribe medications and include the following details:
 - a. Name of child and name of medication
 - b. Dose, route and time of medication to be given
 - c. Any special instructions about the child receiving the medication or about the medicine itself.
 - d. Start and Stop date of the medication
 - e. Possible side effects and/or adverse reactions to the medication
 - g. Name of the health care provider and how to locate or communicate with him or her if necessary
7. _____ Provide the school with a new *Request for Medication Administration in School* form when there are any changes to the above details.
8. _____ Provide each medication in a separate pharmacy-labeled container that includes the child's name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication.

Note: The parent should request of the pharmacist to provide two labeled containers – one for home use and one for school use – if child needs to be given medication both at home and at school.
9. _____ Provide the school with new, labeled containers when dosage or medication changes are prescribed.
10. _____ Over the counter medications administered at school should be provided in their original packaging labeled with the student's name.
11. _____ Over the counter medications will be dispensed by health office personnel to students who have written permission from a parent or guardian to receive medication at school, as needed, for a maximum of three consecutive days. To ensure that use of this medication is not masking symptoms of a serious condition in the student, a healthcare provider's order must be submitted to the school health office for administration beyond this three-day period. OTC medications will not be dispensed during the first and last hours of the school day unless approved on a case by case basis.
12. _____ For the protection of all, students are not permitted to have medications in their possession—with the exception of inhalers, EpiPens and diabetic medications and supplies, for which written permission has been given by the child's physician and parents.
13. _____ Retrieve all unused medications from school when medications are discontinued, and/or at end of school year (According to ALA policy) medications will be discarded 3 days from the end of the school year. Medications will not be sent home with students.
14. _____ Maintain communication with staff regarding any changes to the medical treatment or child's need at school.

Parent Signature

Date

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Request for Medication Administration in School

To be completed by physician

Name of Student: _____

School: _____

Medication: (each medication is to be listed on a separate form) _____

Dosage and Route: _____

Time(s) medication is to be given: a.m.: _____ p.m.: _____ PRN: _____

Note: Medication will be given as close to prescribed time as possible but may be given up to one hour before or after prescribed time. Please advise if there is a time specific concern regarding administration.

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.): _____

Contraindications to administration: _____

Physician (printed) Name: _____ Address: _____

Physician Contact Information: Phone: _____ Fax: _____

Physician's Signature: _____ Date: _____

I hereby give permission for my child (named above) to receive medication during school hours; administered by the health aide or director appointed staff. The medication will be furnished by me in the original container, labeled with the child's name and is to be given as stated above. I understand that medication will NOT be accepted if brought in by my child or is loose in a baggie, envelope or other container. I will count the medication with the staff and co-sign off on the medication. I give my consent to American Leadership Academy to contact the prescribing physician and exchange relevant medical information to clarify this medication order. I hereby release the School Board and their agents and employees from all liability that may result from my child taking this medication.

Parent/Guardian signature _____ Date: _____

Please document medication count ***with parent present*** below:

Date	Medication Name	Count	Expiration Date	Parent signature	Employee initials

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Medication Administration Record (2020-2021)

A separate sheet is used for each medication or treatment

Key ↗ : A=Absent FT= Field Trip NS= No Show NM= No Medication in office RF= Refused ED= Early Dismissal

Additional Daily Administrations (PRN Meds only):

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY
1										
2										
3										
4										
5										
6										
7										
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31										

Date	Time	Person Administering (Name & Initials)

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Student Agreement for Self-Carried Medication

Student: _____ Grade: _____

Campus: _____

Parent(s) Printed name: _____

Parent(s) Contact Numbers: _____

Health Care Provider: _____ Phone Number : _____

Type of Medication: Asthma Inhaler Epinephrine Auto-Injector Diabetic Medication/Supplies

Medication: _____ Dose and Time: _____

Medication is permitted in accordance with state laws and district policy, both student's health care provider and parent guardian must complete Medication Authorizations Form. Students name must appear on medications and devices.

Student Responsibilities

- *I will keep my asthma inhaler, Epinephrine Auto Injector, or diabetes medication/supplies with me at school.*
- *I agree to use my asthma inhaler, Epinephrine Auto-Injector, or diabetes medication/supplies in a responsible manner, in accordance with my licensed health care providers orders.*
- *I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition*
- *I will not allow any other person to use my medication or equipment.*

Student Signature: _____ Date: _____

- ___ Emergency Action Plan complete and on file at school
- ___ Demonstrates correct use/administration
- ___ Verbalizes proper and prescribed timing for medication
- ___ Can describe own health condition well
- ___ Keeps a second labeled container in health office or main office
- ___ Will not share medication or equipment with others

As the parent/guardian of the above-named student, I acknowledge that American Leadership Academy, its employees, or agents shall incur no liability as a result of any injury arising from the self-administration or misuse of the above-named medication by the above-named student; or if the above named-student does not have the medication with them when needed; or if the medication carried by the above-named student has passed its expiration date. I agree to hold harmless the school and its employees or agents against any claims arising out of such self-administration.

Parent Signature: _____ Date: _____

Emergency Contact: Name: _____ Phone Number: _____

Health Aide Signature: _____ Date: _____

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DIABETIC EMERGENCY CARE PLAN FOR THE BUS DRIVER

ALA CAMPUS: _____ SCHOOL YEAR: 20____/20____

STUDENT NAME: _____ CARRIES SUPPLIES: ___ YES ___ NO

(SUPPLIES SHOULD INCLUDE: GLUCOMETER, FAST ACTING SUGAR OR GLUCOSE TABLETS)

BUS # _____ ROUTE # _____ GRADE: _____ TEACHER: _____

PARENT/GUARDIAN NAME: _____

PHONE #: _____ CELL #: _____

PRESENTING PROBLEM INFORMATION:

LOW BLOOD SUGAR (DIABETES)

Student may be hungry, sweating, have a headache, appear fussy or cranky.

EMERGENCY PLAN:

1. **STOP** the bus.
2. Check their blood sugar with glucometer if available. If no glucometer not available, treat with sugar anyway.
3. Look in backpack for a source of sugar.
4. If awake, give juice, regular soda (not diet), 4 glucose tablets (provided by parent), or another source of sugar right away.
5. Wait 15 min then recheck blood sugar, if still low, give another source of sugar. Call parent and school to notify of situation.
6. Call 911 if student does not respond or is having a seizure.
7. Report incident to school and parent.