Each student with diabetes is required to have a Diabetic Medical Management Plan (DMMP) on file at the beginning of the school year or upon returning to school after being diagnosed. The Health Care Provider may prefer to use their own DMMP, or you may submit the DMMP provided here. Additionally, an Authorization to Administer Medication Form is required for each form of Insulin, Glucagon, as well as any over-the-couner medications to be administered while at school. Lastly, a Consent for Release of Medical Information Form is included and only needs to be completed and signed by a parent/guardian if you prefer for the nurse to fax all the necessary forms to the physician to be completed. After signing the Permission to Exchange Information Form and all the required forms, please send them to the school to be faxed to the physician.

AUTHORIZATION TO ADMINISTER PRESCRIPTION & NON-PRESCRIPTION MEDICATION

NAME ______________________ **SCHOOL** ______________ **GRADE** ______

☐ SCHEDULED

MEDICATION ______________________ **DOSAGE** ________ ☐ AS NEEDED **TIME** ______

REASON FOR GIVING ______________________ **START DATE** ________ **END DATE** ________

THIS SECTION REQUIRED FOR PRESCRIPTION MEDICATIONS ONLY

____
Physician Signature
(Or copy of current label)

I have prescribed the medication(s) below and authorize the nurse or the principal designee to administer the medication(s) as follows with time adjustments to accommodate lunches, late arrival, early dismissal, etc.

____
Physician Signature
(Must be signed for student to self-carry)

This patient has demonstrated they are capable of following the instructions regarding safe and appropriate use of this emergency medication and should be permitted to carry this medication provided permission has been granted per school guidelines *(Controlled substances not permitted to be carried by student).*

______________________ ______________ ________
Healthcare Practitioner Name (Printed) **Phone Number** **Date**

PARENT AGREEMENT/AUTHORIZATION:

- The nurse and/or the principal designee has my permission to administer this medication to my child as prescribed and/or directed
- The parent/guardian is responsible for supplying this medication to the school in an original labeled container (this includes pharmacy labels for prescription medications)
- The parent/guardian is responsible for replacing medications on/before their expiration dates
- Changes to the medication dosage and/or administration frequency require a new Authorization to Administer Medication Form be completed along with physician signature or updated pharmacy label for prescription medications
- Authorization to Administer Medication Form must be renewed each school year
- Student's may not be in possession of or transport medications without a current Authorization to Administer form on file
- Medications not picked up at the end of the school year will be disposed of properly
- Parent/Guardian is responsible for notifying the nurse or principal designee if the medication is not to be given for any reason (late arrival, early dismissal, discontinuation, etc.)

______________________ ______________________ ________
Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

AUTHORIZATION TO ADMINISTER PRESCRIPTION & NON-PRESCRIPTION MEDICATION

NAME ______________________ **SCHOOL** ______________________ **GRADE** ________

MEDICATION ______________________ **DOSAGE** ____________ ☐ SCHEDULED ☐ AS NEEDED **TIME** ________

REASON FOR GIVING ______________________ **START DATE** ________ **END DATE** ________

THIS SECTION REQUIRED FOR PRESCRIPTION MEDICATIONS ONLY

____
Physician Signature
(Or copy of current label)

I have prescribed the medication(s) below and authorize the nurse or the principal designee to administer the medication(s) as follows with time adjustments to accommodate lunches, late arrival, early dismissal, etc.

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This patient has demonstrated they are capable of following the instructions regarding safe and appropriate use of this emergency medication and should be permitted to carry this medication provided permission has been granted per school guidelines *(Controlled substances not permitted to be carried by student).*

______________________ **Healthcare Practitioner Name (Printed)**

______________________ **Phone Number**

______________________ **Date**

PARENT AGREEMENT/AUTHORIZATION:

- The nurse and/or the principal designee has my permission to administer this medication to my child as prescribed and/or directed
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- Medications not picked up at the end of the school year will be disposed of properly
- Parent/Guardian is responsible for notifying the nurse or principal designee if the medication is not to be given for any reason (late arrival, early dismissal, discontinuation, etc.)

______________________ **Parent/Guardian Printed Name**

______________________ **Parent/Guardian Signature**

______________________ **Date**

Student Name: ____ Date: __________ Class: _______

Dear Parents/Guardian,

In preparation for the end of the school year, we must coordinate the return of any remaining medication your child has at school. Per Duneland School Corporation policy, medication that is possessed by a school for administration during school hours may be released to the student's parent/guardian or to an individual who is 18 years of age or older and who has been designated, in writing, by the student's parent/guardian to receive the medication. A school may send medication not classified as a controlled substance that is possessed by a school for administration during school hours with a student only if the student's parent/guardian provides written permission for the student to receive the medication. The completion of this form and submission to the school nurse serves as an official written permission.

Medication Returned: QTY NAME OF MEDICATION

__________ _________________________________

__________ _________________________________

__________ _________________________________

_________ I will pick up my child's medication by ___________________ and understand that any medications not picked up on or before Thursday, May 30, 2024 or medications not being forwarded to summer school will be discarded.

_________ Please send my child's medication home no sooner than_______________________ (Controlled substances cannot be sent home with student)

_________ Please forward my child's medication to _______________school for 2024 summer school

_________ I authorize ________________________ who is at least 18 years of age to pick up my child's medication on or before Thursday, May 30, 2024

____

Parent/Guardian Name (Printed)

____ _______________

Parent/Guardian Signature Date

Inspire | Engage | Empower

Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes 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 accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of plan: ______________________ This plan is valid for the current school year: __________–__________

Student information

Student's name: ____ Date of birth: ______________________

Date of diabetes diagnosis: ______________________ ☐ Type 1 ☐ Type 2 ☐ Other: ______________________

School: ____ School phone number: ______________________

Grade: ______________________ Homeroom teacher: ____

School nurse: ____ Phone: ______________________

Contact information

Parent/guardian 1: ____

Address: ____

Telephone: Home: ______________________ Work: ______________________ Cell: ______________________

Email address: ____

Parent/guardian 2: ____

Address: ____

Telephone: Home: ______________________ Work: ______________________ Cell: ______________________

Email address: ____

Student's physician/health care provider: ____

Address: ____

Telephone: ______________________ Emergency number: ______________________

Email address: ____

Other emergency contacts:

Name: ______________________ Relationship: ______________________

Telephone: Home: ______________________ Work: ______________________ Cell: ______________________

Checking blood glucose

Brand/model of blood glucose meter: ____________________

Target range of blood glucose:

Before meals: ☐ 90–130 mg/dL ☐ Other: __________

Check blood glucose level:

☐ Before breakfast ☐ After breakfast ☐ ____ Hours after breakfast ☐ 2 hours after a correction dose

☐ Before lunch ☐ After lunch ☐ ____ Hours after lunch ☐ Before dismissal

☐ Mid-morning ☐ Before PE ☐ After PE ☐ Other: __________

☐ As needed for signs/symptoms of low or high blood glucose ☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Side of fingertip ☐ Other: __________

Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires a school nurse or trained diabetes personnel to check blood glucose

☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM): ☐ Yes ☐ No Brand/model: ____________________

Alarms set for: Severe Low: __________ Low: __________ High: __________

Predictive alarm: Low: __________ High: __________ Rate of change: Low: __________ High: __________

Threshold suspend setting: ____________________

Additional information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level. If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- 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 any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-care CGM Skills	Independent?	
The student troubleshoots alarms and malfunctions.	☐ Yes	☐ No
The student knows what to do and is able to deal with a HIGH alarm.	☐ Yes	☐ No
The student knows what to do and is able to deal with a LOW alarm.	☐ Yes	☐ No
The student can calibrate the CGM.	☐ Yes	☐ No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ Yes	☐ No

The student should be escorted to the nurse if the CGM alarm goes off: ☐ Yes ☐ No

Other instructions for the school health team: ____________________

Hypoglycemia treatment

Student's usual symptoms of hypoglycemia (list below): ____________________

____

____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _______ mg/dL, give a 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.

Additional treatment: ____________________

____

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

- Position the student on his or her side to prevent choking.
- Give glucagon: ☐ 1 mg ☐ ½ mg ☐ Other (dose) ___________
  - Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
  - Site for glucagon injection: ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: ___________
- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Contact the student's health care provider.

Hyperglycemia treatment

Student's usual symptoms of hyperglycemia (list below): ____________________

____

____

- Check ☐ Urine ☐ Blood for ketones every ____ hours when blood glucose levels are above _______ mg/dL.
- For blood glucose greater than _______ mg/dL AND at least ____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _______ mg/dL.
- For insulin pump users: see **Additional Information for Student with Insulin Pump**.
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): ______ ounces per hour.

Additional treatment for ketones: ____________________

- Follow physical activity and sports orders. (See **Physical Activity and Sports**)

If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

Insulin therapy

Insulin delivery device: ☐ Syringe ☐ Insulin pen ☐ Insulin pump

Type of insulin therapy at school: ☐ Adjustable (basal-bolus) insulin ☐ Fixed insulin therapy ☐ No insulin

Insulin therapy (continued)

Adjustable (Basal-bolus) Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:** Name of insulin: ____
- **Carbohydrate Coverage:**

Insulin-to-carbohydrate ratio:

Breakfast: 1 unit of insulin per ______ grams of carbohydrate

Lunch: 1 unit of insulin per ______ grams of carbohydrate

Snack: 1 unit of insulin per ______ grams of carbohydrate

Carbohydrate Dose Calculation Example
Total Grams of Carbohydrate to Be Eaten* / *Insulin-to-Carbohydrate Ratio = ____ ***Units of Insulin***

Correction dose: Blood glucose correction factor (insulin sensitivity factor) = ______ Target blood glucose = ______ mg/dL

Correction Dose Calculation Example
Current Blood Glucose – Target Blood Glucose* / *Correction Factor = ____ ***Units of Insulin***

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose ______ to ______ mg/dL, give ______ units Blood glucose ______ to ______ mg/dL, give ______ units

Blood glucose ______ to ______ mg/dL, give ______ units Blood glucose ______ to ______ mg/dL, give ______ units

See the worksheet examples in **Advanced Insulin Management: Using Insulin-to-Carb Ratios and Correction Factors** for instructions on how to compute the insulin dose using a student's insulin-to-carb ratio and insulin correction factor.

When to give insulin:

Breakfast

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than ______ mg/dL and ____ hours since last insulin dose.

☐ Other: ___________

Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than ______ mg/dL and ____ hours since last insulin dose.

☐ Other: ___________

Snack

☐ No coverage for snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than ______ mg/dL and ____ hours since last insulin dose.

☐ Correction dose only: For blood glucose greater than ______ mg/dL AND at least ____ hours since last insulin dose.

☐ Other: ___________

Insulin therapy (continued)

Fixed Insulin Therapy Name of insulin: ______________________________

☐ _______ Units of insulin given pre-breakfast daily

☐ _______ Units of insulin given pre-lunch daily

☐ _______ Units of insulin given pre-snack daily

☐ Other: ____________

Parents/Guardians Authorization to Adjust Insulin Dose

☐ Yes ☐ No Parents/guardians authorization should be obtained before administering a correction dose.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/– _______ units of insulin.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _______ units per prescribed grams of carbohydrate, +/– _______ grams of carbohydrate.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/– _______ units of insulin.

Student's self-care insulin administration skills:

☐ Independently calculates and gives own injections.

☐ May calculate/give own injections with supervision.

☐ Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.

☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

Additional information for student with insulin pump

Brand/model of pump: ______________________________ Type of insulin in pump: ______________________________

Basal rates during school: Time: __________ Basal rate: ___________ Time: __________ Basal rate: ___________

Time: __________ Basal rate: ___________ Time: __________ Basal rate: ___________

Time: __________ Basal rate: ___________

Other pump instructions: ______________________________

____

Type of infusion set: ______________________________

Appropriate infusion site(s): ______________________________

☐ For blood glucose greater than _______ mg/dL that has not decreased within ____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.

☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Physical Activity

May disconnect from pump for sports activities:	☐ Yes, for ____ hours	☐ No
Set a temporary basal rate:	☐ Yes, ____ % temporary basal for ____ hours	☐ No
Suspend pump use:	☐ Yes, for ____ hours	☐ No

Additional information for student with insulin pump (continued)

Student's Self-care Pump Skills	Independent?	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alarms and malfunctions	☐ Yes	☐ No

Other diabetes medications

Name: ______________________________ Dose: ____________ Route: ____________ Times given: ____________

Name: ______________________________ Dose: ____________ Route: ____________ Times given: ____________

Meal plan

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		____ to ____
Mid-morning snack		____ to ____
Lunch		____ to ____
Mid-afternoon snack		____ to ____

Other times to give snacks and content/amount: ____

____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): ____________

____

Special event/party food permitted: ☐ Parents'/Guardians' discretion ☐ Student discretion

Student's self-care nutrition skills:

☐ Independently counts carbohydrates

☐ May count carbohydrates with supervision

☐ Requires school nurse/trained diabetes personnel to count carbohydrates

Physical activity and sports

A quick-acting source of glucose such as ☐ glucose tabs and/or ☐ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat ☐ 15 grams ☐ 30 grams of carbohydrate ☐ other: _________

☐ before ☐ every 30 minutes during ☐ every 60 minutes during ☐ after vigorous physical activity ☐ other: _________

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

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

(See **Administer Insulin** for additional information for students on insulin pumps.)

Disaster plan

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follows (e.g., dinner and nighttime): ____________________

____

____

☐ Other: ____________________

Signatures

This Diabetes Medical Management Plan has been approved by:

____

Student's Physician/Health Care Provider Date

I, (parent/guardian) ____________________, give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) ____________________ to perform and carry out the diabetes care tasks as outlined in (student) ____________________ Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have 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 school nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

____

Student's Parent/Guardian Date

____

Student's Parent/Guardian Date

____

School Nurse/Other Qualified Health Care Personnel Date

DUNELAND SCHOOL CORPORATION

601 W Morgan Avenue; Chesterton, In 46304
219-983-3600 fax 219-983-3614

Student/ Patient Name:_______________________________________ Date of Birth:________________________

<table>
<tr>
<td>☐ Send from: ☐ Send to:
Duneland School Corporation
(and its affiliates, employees and agents)
601 W Morgan Avenue Chesterton, In 46304
219-983-3600 fax 219-983-3614
Attn: (name and title):
____</td>
<td>☐ Send from: ☐ Send to:
Agency: ____________________________________
(and its affiliates, employees and agents)
Address: __________________________________
City/State: ________________________________
Phone number: _____________________________
Fax number: _______________________________
Attn: (name and title)
____</td>
</tr>
</table>

A. Information to be disclosed:
Typical **School** Information)

- ☐ Transcripts, report cards, attendance reports
- ☐ School Health Records
- ☐ RTI Data/General Education Referral
- ☐ Specialized/Diagnostic Evaluation
- ☐ Special Education Records/Psychological Evaluation
- ☐ Discipline and Behavior Records
- ☐ Other _______________________________

____

(Specific Mental Health/Health Agency Information to be released)

- ☐ Entire medical record including all of below:
- ☐ Medical History/Hospitalization
- ☐ Summary of Psychiatric Treatment
- ☐ Medication History
- ☐ Psychiatric Evaluation Results
- ☐ Mental Disorder/Diagnosis
- ☐ Most Recent Contact Date
- ☐ Drug and Alcohol Information
- ☐ Treatment Plan
- ☐ Clinician's Office Notes
- ☐ Patient Histories
- ☐ Test Results
- ☐ Records sent to you by other health care providers

By signing here, _____________________, I give specific authorization to disclose the following:

☐ HIV test results ☐ Drug and alcohol abuse treatment records ☐ Psychotherapy notes

☐ Documentation of AIDS diagnosis ☐ Psychiatric/Mental health treatment records

B. Purpose of Disclosure:

☐ At the request of the individual or ☐ Other:____

____

C. Authorization to Discuss Health Information

☐ By initialing here ______ (Initial) I authorize ____ (Name of individual health care provider) to discuss my health information with the School listed here:

____

(Name of individual or school entity)

D. Authorization Statements:

- I understand that I am not required to sign this authorization but I further understand that failure to grant authorization for the requested information may limit the school's ability to determine eligibility for services and/or develop an appropriate education plan for the student.
- I understand that the records for which I am authorizing release, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become educational records protected by the Family Educational Rights and Privacy Act. As educational records, they may be subject to re-disclosure.
- I understand that this authorization is valid from the date of my/my representative's signature below and shall expire one year from that date, unless I revoke this authorization in writing.
- I understand that I may withdraw or revoke my permission at any time by writing to the Superintendent of Duneland School Corporation, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I further understand that I am entitled to receive a copy of this authorization, if requested, and that a photocopy of this authorization is as valid as the original.
- I release the individuals and/or organization named in this authorization from legal responsibility or liability for the disclosure of the records authorized on this form.

____ ________________________________

Signature of Adult Consenting to Release (Either Employee or Parent) Date

____ ________________________________

Student Signature (if aged 12 or older) Date