



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 school year) School Year: _____

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: _____



Blood Glucose Monitoring

Student's Checking Skills (*Check One*)

Target Range of Blood Glucose: _____ - _____

Check Blood Glucose:

☐ 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

☐ Before Long exams

☐ Other: _____

☐	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*)
- 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):

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									
Insulin-to-Carbohydrate Ratio: Breakfast: 1 unit of insulin per _____ grams of carbs Lunch: 1 unit of insulin per _____ grams of carbs Snack: 1 unit of insulin per _____ grams of carbs		Correction Factor (Insulin Sensitivity Factor): _____ Target Blood Glucose (BG): _____									
Calculation: <table><tr><td>Total grams of Carbohydrate eaten</td><td>Units of Insulin</td></tr><tr><td>Insulin-to-Carbohydrate Ratio</td><td></td></tr></table>		Total grams of Carbohydrate eaten	Units of Insulin	Insulin-to-Carbohydrate Ratio		Calculation: <table><tr><td>Current BG – Target BG</td><td>Units of Insulin</td></tr><tr><td>Correction Factor</td><td></td></tr></table>		Current BG – Target BG	Units of Insulin	Correction Factor	
Total grams of Carbohydrate eaten	Units of Insulin										
Insulin-to-Carbohydrate Ratio											
Current BG – Target BG	Units of Insulin										
Correction Factor											



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)

☐	Independently calculates and gives own injections
☐	Supervised calculations and injections
☐	Staff to calculate dose and student to give own injection
☐	Staff to calculate dose and student to give injection with supervision
☐	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

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

☐ Student's 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.



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: _____
- Give Baqsimi: ☐ 3mg ☐ Other dose: _____ ☐ Intranasal Use Only
- 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:** _____

Signatures

I (parent/guardian) _____, give permission to the school Health Aide or another qualified health care professional or trained diabetes personnel of Signature Preparatory 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/ School Nurse

Date



Daily Schedule

	Evaluation	Action
Event: Time:	Less than:	Call parents/guardians Never leave alone Give _____grams of fast acting sugar
	—	
	—	
	Greater than:	Call parents/guardians Encourage water or other non-sugary fluids
Event: Lunch Time:	Less than:	Call parents/guardians Never leave alone Give _____grams of fast acting sugar
	—	
	—	
	Greater than:	Call parents/guardians Encourage water or other non-sugary fluids
Event: Snack Time:	Less than:	Call parents/guardians Never leave alone Give _____grams of fast acting sugar
	—	
	—	
	Greater than:	Call parents/guardians Encourage water or other non-sugary fluids



Letter to Parent Regarding Administration of Medication in School

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 website or health office. Take the form to your child's licensed healthcare provider and have him/her complete the form. This form must be completed by the provider for all prescription drugs and over-the-counter medications the form must be signed by the provider and by you, the parent or guardian. Prescription medicines must be brought to school in the 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 unopened original container, labeled with your child's name, and will be administered according to the written instructions on the medication at school form.
3. You may discuss with your provider an alternative schedule for administering medication (i.e. outside of school hours). Please keep in mind that scheduled medication will not be given in the first and last hour of each school day.
4. Self-Medication: Students requiring medication for asthma, anaphylactic reactions, and diabetes may self-medicate with physician authorization, parent permission, student agreement for self-carried medication, and a signed blood-borne pathogen/medical waste acknowledgement. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for, and management of self-carry medications. **If found incompetent by health office personnel, the medication will need to be kept in the health office with the appropriate forms filled out.**
5. School personnel will not administer any prescription or over-the-counter medications to a student unless the school has received a completed *Request for Medication Administration* form that has been signed by both the provider and parent/guardian, and the medication has been received in an appropriately pharmacy-labeled container.

If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school health office.

Thank you for your cooperation,

Health Office Representative _____ Date _____



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. ____ *Initials*
2. Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form (i.e., Request for Medication form). Return completed form to school. A separate parent request/permission form must be completed for each medication given at School. ____ *Initials*
3. Parents may choose to administer the medication at school themselves. ____ *Initials*
4. Complete an Authorization form, signed by a health care provider licensed to prescribe medications, which includes the following:
 - a. Name of child
 - b. Name of medication
 - c. Date it was prescribed
 - d. Dosage
 - e. How the medicine is to be given at school
 - f. When the medicine will be given at school
 - g. Special instructions about the child receiving the medication or about the medicine itself.
 - h. Until what date the medicine is to be given at school
 - i. Possible side effects of the medication
 - j. Possible adverse reactions to the medication
 - k. Name of the health care provider and how to locate or communicate with him/her if necessary
____ *Initials*

5. Provide a completed action plan form if your child has the following diagnoses and will be self-carrying medication/supplies: Asthma, allergies requiring an Epi-pen, Seizures, and/or Diabetes ____ *Initials*
6. 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. The medication pharmacy label on the container must match the doctor's order (request for medication administration).

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. ____ *Initials*

7. Over the counter medications administered at school should be provided in their original packaging labeled with the student's name. ____ *Initials*
8. Provide the school with new, labeled containers when dosage or medication changes are prescribed. ____ *Initials*
9. Retrieve all unused medications from school when medications are discontinued, and /or within 3 days of the date the school year ends. Signature Preparatory reserves the right to discard the medication if not picked up within 3 days ____ *Initials*
10. Maintain communication with the school staff regarding any changes in the medical treatment and child's need at school. ____ *Initials*

Student Name: _____ DOB: _____

Parent/Guardian Signature

Date

Health Office Representative

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: _____

**This form is invalid unless stamped and signed by the healthcare provider*

I hereby give permission for my child (named above) to receive medication during school hours; administered by the health office or 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 hereby release Signature Preparatory, 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 (2025-2026)

Student Name: _____ DOB: _____

Medication Name/Dosage/Route: _____

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

A separate sheet is used for each medication or treatment

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY
1										
2										
3										
4										
5										
6										
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Date	Time	Person Administering (Name & Initials)



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Student Agreement for Self-Carried Medication

Student: _____ **Grade:** _____

Parent/Guardian Printed Name: _____ **Phone Number:** _____

Emergency Contact Name: _____ **Phone Number:** _____

Health Care Provider: _____ **Phone Number:** _____

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

Medication: _____ **Dose and Time:** _____

Purpose: _____

Potential Side Effects: _____

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. Student name must appear on medications and devices.

Student Responsibilities

- o I will keep my asthma inhaler, Epinephrine Auto Injector, or diabetes medication/supplies with me at school.*
- o 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.*
- o I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition.*
- o I will not allow any other person to use my medication or equipment.*
- o I will discard any medical waste potentially contaminated with biological hazards under supervision of a health office designee.*

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
- ___ Will not share medication or equipment with others

As the parent/guardian of the above-named student, I have received a copy of the protocols for containing blood-borne pathogens and the handling and disposal of needles, medical devices and other medical waste. I further acknowledge that the above-named student will be held accountable for following the set protocols. Their authorization to self-administer medication may be revoked if the student fails to comply with the protocols for containing blood-borne pathogens and safe-handling/disposal of needles, medical devices, and other medical waste.

As the parent/guardian of the above-named student, I grant permission for the student to carry and self-administer the above-named medication while on campus or participating in an activity sponsored by the school. I acknowledge that Signature Preparatory, its employees, or agents shall incur no liability as a result of any injury/death arising from the self-administration, failure to administrate when needed, or misuse of the above-named medication by the student. I agree to hold harmless the school and its employees or agents against any claims arising out of such self-administration.

Parent/Guardian Signature: _____ **Date:** _____

School Nurse/Principal: _____ **Date:** _____

Physician Signature: _____ **Date:** _____



Proper Handling and Disposal of Medical Waste and Devices

In order to ensure the safety of all students and staff from bloodborne pathogens, Signature Preparatory follows the guidelines developed by the Centers of Disease Control (CDC) and the Occupational Safety and Health Administration (OSHA). In accordance with the Occupational Safety and Health Administration (OSHA) Blood-Borne Pathogens Standard, 29 CFR 1910.1030, Signature Preparatory has developed an Exposure Control Plan (ECP) in order to provide a secure and healthful work environment for all staff. It is imperative that everyone follows these regulations and incorporates safe practices in order to substantially reduce the risk of contracting a bloodborne disease while on the job.

Bloodborne pathogens are microorganisms carried by human blood and other body fluids. The two most common are the hepatitis B virus (HBV), hepatitis C (HBC) and the human immunodeficiency virus (HIV). Unfortunately, children are as prone to bloodborne diseases as adults are. Many children need their medication during school hours routinely or need to have it on campus in case of an emergency situation. Without their inhalers, Epinephrine injections, insulin injections, etc., this could potentially lead to a life-threatening situation.

All students and staff should follow standard precautions to help prevent the spread of bloodborne pathogens and other diseases whenever there is a risk of exposure to blood or other body fluids. These precautions require that all blood and other body fluids be treated as if they are infectious. Standard precautions include maintaining personal hygiene and using personal protective equipment (PPE), engineering controls, and proper equipment cleaning and storage procedures.

Thoroughly wash your hands and other areas immediately after self-administering your medication. The CDC recommends following these five steps every time:

1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
4. Rinse your hands well under clean, running water.
5. Dry your hands using a clean towel or an air dryer.

Use alcohol-based hand sanitizer of minimum 60% alcohol, only when a hand-washing facility is not available. Please keep in mind that hand sanitizer does not get rid of all types of germs and will not be effective when hands are visibly dirty or greasy. Cover all surfaces of your hand and rub your fingers and hands together until they are dry. Once a hand-washing facility is readily available, the student must wash their hands with soap and water as well. When practical, also wash your hands before taking your medication.

All needles (e.g., Glucagon, Insulin, Epinephrine pens, lancets, etc.) must be discarded in a Signature Preparatory sharps container. You can become infected by cutting yourself with a contaminated sharp object. Only the student that is self-administering the medication should be the one handling the medication at all times until discarding. Parents of insulin-dependent diabetic students should provide a sharps container for safe disposal of lancets and syringes for their child. If unable to provide this device, please contact the Signature Preparatory health office immediately. All containers should be discarded in accordance with State procedures when the container is 2/3rd full.



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When the container is full, the parents should be notified to pick it up and dispose of it as home medical waste. Sharps containers must be stored in a locked cabinet to prevent access by others. For management in the health office, a sharps container is readily available.

You must wear gloves when it is reasonably anticipated your hands may contact: blood, potentially infectious materials, mucous membranes, or non-intact skin. Replace gloves as soon as you can if they are torn or punctured. Due to the risk of becoming torn or punctured, all open wounds on hands and/or fingers must be bandaged before placing the gloves on. Please keep in mind that gloves do not replace hand-washing. Handwashing is one of the best ways to protect yourself and others around you.

All students and employees must follow universal precautions to prevent contact with blood or other potentially infectious materials. PPE that can be worn may include: gloves, masks, protective eyewear, masks, etc. Signature Preparatory health office will issue personnel protective equipment and have it readily accessible as needed to you.

Please remember that accidents happen. If you are exposed or there is a medication spill, immediately report the incident to the health office so they can properly assist with post-exposure care, referrals, and/or clean up. The authorization to self-administer medication may be revoked if the student fails to comply with the protocols for containing blood-borne pathogens and safe-handling/disposal of needles, medical devices, and other medical waste. Remember that an exposure may potentially lead to infection. Using standard precautions may literally save your life.

Resources:

<https://www.cdc.gov/handwashing/when-how-handwashing.html>

https://www.redcross.org/content/dam/redcross/atg/PDFs/Take_a_Class/Bloodborne-Pathogens-Fact-and-Skill-Sheets.pdf

<https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030>

http://www.creighton.edu/fileadmin/user/SchoolHealth/docs/Blood_borne_pathogen_training.pdf