

DIABETES MEDICAL MANAGEMENT PLAN (DMMP)

Student Name: _____ **Date of Birth:** _____

Parent/Guardian: Please complete the contact information section on this page and sign pages 3 and 4 of DMMP.

Healthcare provider: Please complete all remaining sections of DMMP, including all blank fields on page 3 (Emergency Care Plan). Also, please sign page 3 and include your signature and office stamp on page 4 of DMMP. A Check 'not applicable' where appropriate. All incomplete or unsigned DMMPs will be returned for completion before implementation at school.

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

CONTACT INFORMATION

Parent/Guardian #1: _____ Preferred Contact Number: _____
 Parent/Guardian #2: _____ Preferred Contact Number: _____
 Emergency Contact Name: _____ Relationship: _____ Contact Number: _____
 Diabetes Healthcare Provider: _____ Phone Number: _____ Fax Number: _____
 Diabetes Educator Name: _____ Phone Number: _____ Email: _____

STUDENT DIABETES MANAGEMENT SKILLS

Check only one skill level for each category. If more than one level is selected in one category, the lowest skill level will be applied.	INDEPENDENT Provides self-care	SUPERVISION Requires supervision	DEPENDENT Needs full support by trained staff
Performs blood glucose testing, interprets and responds to blood glucose/CGM results and alarms	☐	☐	☐
Performs hyperglycemia and hypoglycemia management	☐	☐	☐
Calculates carbohydrate grams	☐	☐	☐
Determines insulin dose for carbohydrate intake	☐	☐	☐
Determines correction dose of insulin for high blood glucose	☐	☐	☐
Performs insulin administration	☐	☐	☐

DIABETES SUPPLIES

If the student is permitted to self-carry diabetes supplies, check all that apply below.
 Supplies must be provided by parent/guardian and replenished throughout school year.

Blood glucose meter, strips, lancets, lancing device	☐
Insulin pen, pen needles, insulin cartridge, insulin syringes	☐
Fast acting carbohydrates (glucose tabs, glucose gel, juice, etc.)	☐
Ketone test strips	☐
Glucagon	☐
Insulin Pump	☐
Monitoring device for CGM or insulin pump	☐
Snacks	☐

Per [Florida Statute 1002.20\(3\)\(j\)](#) students with diabetes may carry diabetes supplies and equipment on their person and provide self-care with written authorization from their parent and physician. The written authorization shall identify the diabetes supplies and equipment that the student is authorized to carry.

BLOOD GLUCOSE (BG) MONITORING

☐ Check Here if Not Applicable

TYPE OF MONITOR:

☐ Glucometer ☐ Continuous Glucose Monitor (CGM) ☐ Only confirm CGM result with finger stick if < _____ mg/dL or > _____ mg/dL

TIME(S) FOR BLOOD GLUCOSE (BG) MONITORING TO BE PERFORMED

☐ Before breakfast	☐ After PE/activity time
☐ Mid-morning (before snack)	☐ Before PE/activity time, give snack if BG < _____ mg/dL
☐ Before lunch	☐ Before dismissal, give snack if BG < _____ mg/dL
☐ Mid-afternoon	☐ As needed for signs /symptoms of low/high blood glucose

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SUBCUTANEOUS (SQ) INSULIN ADMINISTRATION

Does student require insulin administration during school and/or during school sponsored activities? ☐ Yes ☐ No

INSULIN DELIVERY: CHECK ALL THAT APPLY

☐ N/A ☐ Syringe/vial ☐ Pen ☐ InPen ☐ Pump Dosing determined by insulin pump. Follow pump dosing calculations unless failure is suspected. If pump fails or unavailable, other insulin delivery may be used.

Long-Acting insulin at school	Standard daily insulin at school	Fast-Acting (FA) insulin at school	Outside Mealtimes (PRN)
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO ☐ Use sliding scale
Insulin name: _____	Insulin name: _____	Insulin name: _____	☐ Use Correction Dose for BG greater than _____ mg/dL AND at least _____ hours since last FA insulin dose AND _____ hours since last meal
Dose: _____ units	Dose: _____ units	Time: _____	
Time: _____	Time: _____		

CARBOHYDRATE INSULIN RATIO

(For whole unit: 0.1 to 0.4 = round down to whole unit. 0.5 to 0.9 = round up to whole unit. For ½ unit: 0.1 to 0.3 = round down to whole unit. 0.4 to 0.7 = round to ½ unit. 0.8 to 0.9 = round up to whole unit). OR ☐ Use Other Rounding: _____

MEAL	CORRECTION REQUIRED	ONE UNIT OF INSULIN PER AMOUNT OF CARBOHYDRATE GRAMS CONSUMED	CARBOHYDRATE COVERAGE NOT REQUIRED
☐ Breakfast	1 unit of insulin per	_____ grams of carbohydrates consumed	☐
☐ AM Snack	1 unit of insulin per	_____ grams of carbohydrates consumed	☐
☐ Lunch	1 unit of insulin per	_____ grams of carbohydrates consumed	☐
☐ PM Snack	1 unit of insulin per	_____ grams of carbohydrates consumed	☐
☐ Other	1 unit of insulin per	_____ grams of carbohydrates consumed	☐

CORRECTION FACTOR

☐ Check here if Not Applicable Rounding (indicate above)

BG minus Target BG _____ mg/dL divided by correction factor _____ = Correction Dose (units of insulin to administer)

If correction dose is administered within _____ hour(s) prior to meal, **ONLY** administer insulin to cover carbohydrates

Note: Correction Dose + Carbohydrate Coverage Dose = Total Insulin Required

INSULIN SLIDING SCALE

☐ Check Here if Not Applicable

BLOOD GLUCOSE MG/DL	INSULIN DOSE (NUMBER OF UNITS)
Blood Glucose Range: _____ mg/dL to _____ mg/dL	_____ units
Blood Glucose Range: _____ mg/dL to _____ mg/dL	_____ units
Blood Glucose Range: _____ mg/dL to _____ mg/dL	_____ units
Blood Glucose Range: _____ mg/dL to _____ mg/dL	_____ units
Blood Glucose Range: _____ mg/dL to _____ mg/dL	_____ units

GLUCAGON ADMINISTRATION

Is student prescribed glucagon for hypoglycemia emergencies while in school? ☐ Yes (if yes, indicate type below) ☐ No

☐ Glucagon Emergency Kit IM or SQ ☐ 0.5mg OR ☐ 1.0mg ☐ Baqsimi (nasal) 3 mg

☐ Gvoke SQ ☐ 0.5mg OR ☐ 1.0mg ☐ Zegalogue SQ 0.6mg ☐ Other: _____

PHYSICAL ACTIVITY, SPORTS AND EMERGENCY SITUATIONS (e.g. lockdown, fire, etc.)

Student **MUST** have quick access to water, fast-acting carbohydrates, monitoring equipment and diabetes medication.

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MANAGEMENT OF HYPERGLYCEMIA - HIGH BLOOD GLUCOSE (BG)			
Indicate hyperglycemia level here: Over _____ mg/dL			
TYPICAL SIGNS/SYMPTOMS OF HYPERGLYCEMIA			
Increased thirst/urination Increased hunger	Increased urination Tired/sleepiness	Warm dry flushed skin Blurred vision	Sweet, fruity breath Other: _____
Initial Treatment of Moderate Hyperglycemia - Immediately contact the School Health Service Provider - Give extra water and/or sugar-free fluids as tolerated - Use insulin correction factor if: BG is > _____ mg/dL and it has been _____ hours since last insulin dose - Unlimited bathroom privileges - Check urine ketones if: BG > _____ mg/dL <i>If blood glucose is > 300 mg/dL one hour after treatment, recheck ketones, and follow ketone management protocol</i>	If ketones are negative or trace: - It is not necessary for the student to go home or remain in the clinic - Return to clinic in 1 hour to recheck blood glucose	If ketones are small or greater: - Stay with the student and document changes in status - Call parent; if unable to contact, call School Health Service Provider for instructions and/or contact diabetes care provider	
EMERGENCY HYPERGLYCEMIA SIGNS/SYMPTOMS			
When these signs/symptoms are present with hyperglycemia call 911/Emergency Medical Services (EMS)			
- Vomiting - Severe abdominal pain	- Rapid, labored breathing - Increased sleepiness/lethargy	- Very weak - Depressed consciousness level	

MANAGEMENT OF HYPOGLYCEMIA - LOW BLOOD GLUCOSE			
Indicate hypoglycemia level here: Below _____ mg/dL			
MILD TO MODERATE HYPOGLYCEMIA SIGNS/SYMPTOMS			SEVERE HYPOGLYCEMIA SYMPTOMS (mild to moderate symptoms <i>plus</i> below)
Hunger Agitation Nausea/stomachache Blurred vision	Disoriented Weak/lethargic Sweaty/clammy Dizziness/shaky	Personality changes Headache Pale skin Inattention/confused	Slurred speech Inability to swallow Unconscious Unresponsive Seizure activity or convulsions Other: _____
Treatment for Mild to Moderate Hypoglycemia - Test Blood Glucose (BG) ☐ Give _____ grams of fast-acting carbohydrates such as: _____ glucose tablets (preferred) _____ oz. fruit juice or non-diet soda _____ oz. of milk - Other: _____ - Retest BG 15 minutes after treatment - Repeat treatment until BG over _____ mg/dL - If more than 1 hour until next meal/snack or if going to activity, treat with 15g of complex carbohydrate/protein snack - No exercise if BG is below 70 mg/dL			Treatment for Severe Hypoglycemia If the student is unconscious, unresponsive or is having a seizure, do the following: - Suspend insulin pump if in use - Administer glucagon as ordered on the DMMP - While treating, instruct another person to call 911 - Position student on his/her/their side and maintain position - Contact student's parent/guardian - Stay with the student until EMS arrives - Advise EMS of insulin delivery method - Notify the student's diabetes healthcare provider

Healthcare Provider Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

School Health Service Provider (i.e.: nurse/UAP/trained personnel) Name: _____

Signature: _____ Date: _____

A copy of this page will be kept in the clinic and provided to all staff in regular contact with the student.

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SIGNATURES

Parent/guardian please read, complete, and sign. By signing below, I agree to the following:

The Diabetes Medical Management Plan (DMMP) is a healthcare provider order and is valid for one full year from the date signed by the healthcare provider. This form represents my consent and request for my child to receive the diabetes care described DMMP. This DMMP may be sent directly to The School Board of Broward County, Florida, SBBC.

I give permission to school health service providers, unlicensed assistive personnel (UAP) and approved vendor healthcare providers working with SBBC to perform and carry out the diabetes care as outlined in this DMMP. I understand that this DMMP can only be revised by a healthcare provider and no verbal orders will be accepted from the parent/guardian. It is my responsibility to notify the school if there is a change to my child's DMMP prior to its expiration date. Diabetes care may include but is not limited to, medication administration and clinical/physical assessments and *does not* include adjustments/changes to insulin pump and CGM sites or settings. Insulin pump dosing may be suspended temporarily in case of severe hypoglycemia emergency.

I consent to the release of information contained in this DMMP to all school staff and other adults responsible for my child, as needed, to help ensure my child's health and safety.

I give permission to school health service providers to collaborate with my child's healthcare providers and request information about my child's medical condition, medication, or treatment.

PARENT/GUARDIAN INFORMATION

I hereby authorize and direct that my child's diabetes care be administered in the manner set forth in this DMMP. I understand that all medications, snacks and supplies are to be supplied/restocked by the parent/guardian.

Parent/Guardian Name: _____

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

HEALTHCARE PROVIDER INFORMATION

By signing this form, I certify that this DMMP has been discussed with the parent/guardian.

Healthcare Provider Name: _____

Signature: _____ **Date:** _____

Healthcare Provider Stamp: _____

SCHOOL HEALTH SERVICE PROVIDER (I.E. NURSE, UAP, TRAINED PERSONNEL) INFORMATION

By signing this form, I acknowledge that I have reviewed these orders and agree to carry out the DMMP as specified by the healthcare provider.

School Health Service Provider Name: _____

School Health Service Provider Signature: _____ **Date:** _____