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Student Health & Medical Plans
DMMP & SAP
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Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardian. 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'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

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work_____Cell:_____

Email Address: _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell:_____

Email Address: _____

Student's Physician/Health Care Provider: _____

Address: _____

Telephone: _____

Email Address:_____Emergency Number: _____

Other Emergency Contacts:

Name: _____ Relationship:_____

Telephone: Home _____ Work_____ Cell:_____

CHECKING BLOOD GLUCOSE

Target range of blood glucose: ☐ 70-130 mg/dL ☐ 70-180 mg/dL

☐ Other: _____

Check blood glucose level: ☐ Before lunch ☐ _____ Hours after lunch

☐ 2 hours after a correction dose ☐ Mid-morning ☐ Before PE ☐ After PE

☐ Before dismissal ☐ Other: _____

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

☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Fingertip ☐ Forearm ☐ Thigh ☐ Other: _____

Brand/Model of blood glucose meter: ___

Note: 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 school nurse or trained diabetes personnel to check blood glucose

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No

Brand/Model: _____ Alarms set for: ☐ (low) and ☐ (high)

Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM

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 10-15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment: _____

HYPOGLYCEMIA TREATMENT (Continued)

Follow physical activity and sports orders (see page 7).

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
- Glucagon: ☐ 1 mg ☐ 1/2 mg Route: ☐ SC ☐ IM
- Site for glucagon injection: ☐ arm ☐ thigh ☐ Other: _____
- Call 911 (Emergency Medical Services) and the student's parents/guardian.
- Contact 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 orders below).

For insulin pump users: see additional information for student with insulin pump.

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 page 7).

- Notify parents/guardian of onset of hyperglycemia.
- If the student has symptoms of a hyperglycemia emergency, including 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: Call 911 (Emergency Medical Services) and the student's parents/guardian.
- Contact student's health care provider.

INSULIN THERAPY

Insulin delivery device: ☐ syringe ☐ insulin pen ☐ insulin pump

Type of insulin therapy at school:

☐ Adjustable Insulin Therapy
☐ Fixed Insulin Therapy
☐ No insulin

Adjustable Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:**

  Name of insulin: _____

- **Carbohydrate Coverage:**

  Insulin-to-Carbohydrate Ratio:

  Lunch: 1 unit of insulin per_____ grams of carbohydrate

  Snack: 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example

$$\frac{\textit{Grams of carbohydrate in meal}}{\textit{Insulin-to-carbohydrate ratio}} = _____ \text{units of insulin}$$

- **Correction Dose:**

Correction Dose Calculation Example

$$\frac{\textit{Actual Blood Glucose—Target Blood Glucose}}{\textit{Blood Glucose Correction Factor/Insulin Sensitivity Factor}} = _____ \text{units of insulin}$$

Blood Glucose Correction Factor/Insulin Sensitivity Factor =

Target blood glucose = mg/dL

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

INSULIN THERAPY (Continued)

When to give insulin:

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.

☐ Other: _____

☐ Correction dose only:

For blood glucose greater than _____ mg/dL AND at least_____hours since last insulin dose.

☐ Other: _____

Fixed Insulin Therapy

Name of insulin: _____

☐ ____ Units of insulin given pre-lunch daily

☐ ____ Units of insulin given pre-snack daily

☐ Other: _____

Parental Authorization to Adjust Insulin Dose:

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

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/-_____units of insulin.

☐ Yes ☐ No Parents/guardian 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/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/-_____ units of insulin

INSULIN THERAPY (Continued)

Student's self-care insulin administration skill

☐ Yes ☐ No Independently calculates and gives own injections
☐ Yes ☐ No May calculate/give own injections with supervision
☐ Yes ☐ No Requires school nurse or trained diabetes personnel to calculate/give injections

ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP

Brand/Model of pump: _____ Type of insulin in pump: _____

Basal rates during school: _____

Type of infusion set: _____

☐ For blood glucose greater than_____mg/dL that has not decreased within _____hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir.

☐ 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 ☐ No
Set a temporary basal rate ☐ Yes ☐ No_____% temporary basal for_____hours
Suspend pump use ☐ Yes ☐ No

Student's self-care pump skills:	**Independent?**
Count carbohydrates	☐ Yes ☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes ☐ No
Calculate and administer correction bolus	☐ Yes ☐ No
Calculate and set basal profiles	☐ Yes ☐ No
Calculate and set temporary basal rate	☐ Yes ☐ No
Change batteries	Yes No
Disconnect pump	☐ Yes ☐ No
Reconnect pump to infusion set	☐ Yes ☐ No
Prepare reservoir and tubing	☐ Yes ☐ No
Insert infusion set	☐ Yes ☐ No
Troubleshoot 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/guardian discretion
☐ Student discretion

Student's self-care nutrition skills:

☐ Yes ☐ No Independently counts carbohydrates

☐ Yes ☐ No May count carbohydrates with supervision

☐ Yes ☐ No 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 ☐ 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.

(Additional information for student on insulin pump is in the insulin section on page 6.)

DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follows: _____

☐ 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:)_____'s 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

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

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