**DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
F-43013 (Rev. 03/10)

**STATE OF WISCONSIN**
(608) 261-6855

# DIABETES MEDICAL MANAGEMENT PLAN

***The student's healthcare provider and parents/guardians should complete this form.*** *Please fill out entire form. Review with relevant school personnel who have an educational and safety interest in students with diabetes. Keep copies to share with the school nurse, trained school personnel, and other authorized personnel.*

**Current Date** _____

**Student Information**

Student Name: _____ Date of Birth: _____

School Grade No.: _____ Homeroom Teacher: _____

School Name: _____ School District: _____

Type of Diabetes: _____ Date Diagnosed: _____ Last A1C date/result: _____ A1C Goal: _____

**Parent/Guardian Contact Information**

Mother/Guardian: _____

Email: _____

Address: _____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Father/Guardian: _____

Email: _____

Address: _____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

**Health Care Provider and Emergency Contact Information**

Student's Primary Health Care Provider: _____ Telephone: ( ) _____

Nurse: _____ Telephone: ( ) _____

Endocrine Specialist: _____ Telephone: ( ) _____

Certified Diabetes Educator: _____ Telephone: ( ) _____

Additional Emergency Contact: _____ Relationship: _____

Address: _____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Preferred Hospital: _____

**Notify parents/guardians or additional emergency contact in the following situation(s):**

1) _____
2) _____
3) _____
4) _____

## LOW BLOOD GLUCOSE/HYPOGLYCEMIA

**Symptoms of low blood glucose** *(check most common for student)*:

| **MILD *to…*** | **MODERATE *to…*** | **SEVERE** |
|---|---|---|
| ☐ Hungry | ☐ Mood/behavior change | ☐ Confused/unable to follow commands |
| ☐ Shaky/weak/clammy | ☐ Inattentive/spacey | ☐ Unable to swallow |
| ☐ Blurred vision/glassy eyes | ☐ Slurred/garbled speech | ☐ Unable to awaken (unconscious) |
| ☐ Dizzy/headache | ☐ Anxious/irritable | ☐ Seizure |
| ☐ Sweaty/flushed/hot | ☐ Numbness or tingling around lips | ☐ Convulsion |
| ☐ Tired/drowsy | ☐ Poor coordination | |
| ☐ Fast heartbeat | ☐ Unable to concentrate | |
| ☐ Pale skin color | ☐ Personality change | |
| ☐ Other: _____ | ☐ Other: _____ | |
| ☐ Usually has no symptoms | ☐ Usually has no symptoms | |

**Treatment of low blood glucose** *(Check all that apply)*:

☐ Give _____ grams carbohydrate of <u>one</u> of the following *(check all that apply)*:

☐ _____ oz milk ☐ _____ grams of glucose gel ☐ Other: _____

☐ _____ oz fruit juice ☐ _____ glucose tablets ☐ Other: _____

☐ Recheck blood glucose in 15 minutes ***OR*** ☐ Other: _____

☐ If blood glucose is less than mg/dL, give another grams of carbohydrate

☐ If it is more than 1 hour before next meal/snack give *(circle one)* extra snack or _____ grams of carbohydrate.

*Students using a continuous glucose monitor must always use a finger stick glucose reading to confirm low blood glucose.*

**GLUCAGON *(check all that apply):*** ☐ Not applicable

☐ **Administer Glucagon if student is:** confused/unable to follow commands, unable to swallow, unable to awaken (unconscious), or having a seizure or convulsion

Glucagon Dose *(check)*: □ **0.5 mg** or □ **1.0 mg** Injection site *(check)*: □ **arm** □ **thigh** □ **other** _____

**If student uses an insulin pump and exhibits symptoms of severe low blood glucose, in addition to giving Glucagon:**

☐ Disconnect tubing from student ☐ Other: _____ ☐ Other: _____

## HIGH BLOOD GLUCOSE/HYPERGLYCEMIA

**Symptoms of high blood glucose *(check most common for student):***

| **MILD *to…*** | **MODERATE *to…*** | **SEVERE** |
|---|---|---|
| ☐ Frequent urination/bedwetting | ☐ Mild symptoms, and | ☐ Mild and moderate symptoms, and |
| ☐ Extreme thirst/dry mouth | ☐ Nausea/vomiting | ☐ Labored breathing |
| ☐ Sweet, fruity breath | ☐ Stomach pain/cramps | ☐ Weakness |
| ☐ Tiredness/fatigue | ☐ Dry/itchy skin | ☐ Confusion |
| ☐ Increased hunger | ☐ Unusual weight loss | ☐ Unconsciousness |
| ☐ Blurred vision | ☐ Other: _____ | |
| ☐ Flushed skin | | |
| ☐ Lack of concentration | | |
| ☐ Other: _____ | | |

**Treatment of high blood glucose *(check all that apply)*:**

☐ Provide correction/supplemental dose of insulin *(see Insulin and Insulin Pump sections)*

☐ If blood glucose is: _____ mg/dL **and/or** if student is sick ⇒ **check** ketones in *(check):* ☐ urine ☐ blood

☐ Blood glucose ≥ _____mg/dL **without ketones** recheck blood glucose level in *(check):* ☐ 2 hour

☐ Blood glucose ≥ _____ mg/dL **with ketones** *(check below):*

**If ketones are:**

| **<u>Trace/Small</u>** | **<u>Moderate/Large</u>** |
|---|---|
| ☐ Allow free bathroom access | ☐ Allow free bathroom access |
| ☐ Encourage water and/or other sugar-free fluids | ☐ Encourage water and/or other sugar-free fluids |
| ☐ Recheck blood glucose levels in 2 hours | ☐ Call parents/guardians |
| ☐ Recheck ketones in 2 hours | ☐ Arrange for student to be taken home and/or to see his/her healthcare provider |
| ☐ Other: _____ | ☐ Other: _____ |
| ☐ Other: _____ | |

*Students using a continuous glucose monitor must always use a finger stick glucose reading to confirm high blood glucose.*

## BLOOD GLUCOSE MONITORING

☐ *Not applicable*

Name of glucose monitor: _____

Student will test at school. ☐ Yes ☐ No

Student can perform own blood glucose check. ☐ Yes ☐ No Exceptions: _____

**Target blood glucose range:** _____ to _____ mg/dL

**Routine glucose monitoring at school *(check all that apply):***

☐ Before breakfast ☐ Before morning snack ☐ Before lunch ☐ Before afternoon snack ☐ End of school day

**Additional glucose monitoring at school *(check all that apply):***

☐ Before physical activity/physical education ☐ Symptoms of low blood glucose ☐ Other _____

☐ During physical activity/physical education ☐ Symptoms of high blood glucose ☐ Other _____

☐ After physical activity/physical education ☐ Student becomes sick or is sick ☐ Other _____

## CONTINUOUS GLUCOSE MONITORS (CGM)

☐ *Not applicable*

**Treatment decisions and diabetes care plan adjustments should always be made based upon a meter blood glucose reading.**

Name of CGM: _____

☐ CGM alert for low blood glucose is set at _____ mg/dL ☐ CGM alert for high blood glucose is set at _____ mg/dL

**Check blood glucose by finger stick in these situations *(all apply):***

- Any high or low glucose alert
- Any symptoms of low or high blood glucose
- CGM readings are questionable
- Before insulin or medication is used to lower glucose
- Any time the CGM system is not working
- Other: _____

**Additional comments:**

_____

_____

_____

## SICK DAY

**If a Student comes to school sick or becomes sick at school *(do all the following):***

- Encourage water
- Offer sugar-free fluids
- Check blood glucose (if > _____ see High Blood Glucose section)
- Check Ketones
- Call parents/guardians
- Arrange for student to be excused from school
- Other: _____

## DIABETES SUPPLIES TO BE KEPT AT SCHOOL

☐ Blood glucose monitor, blood glucose test strips, batteries for monitor

☐ Lancet device, lancets, gloves

☐ Urine/blood ketone testing supplies

☐ Insulin vials and syringes

☐ Insulin pump supplies

☐ Insulin pen, pen needles, insulin cartridges

☐ Fast-acting source of glucose

☐ Carbohydrate containing snack

☐ Glucagon emergency kit

☐ Other: _____

☐ Other: _____

☐ Other: _____

## DIABETES ORAL MEDICATION

☐ *Not applicable*

**Name of medication, dose and schedule *(list):***

1. _____
2. _____
3. _____

## INSULIN ☐ *Not applicable*

**Type of Insulin(s) required *(list):*** _____

**Insulin delivery *(check)*:** ☐ Syringe/Vial ☐ Insulin Pen ☐ Insulin Pump (name) _____ ☐ Other: _____

**Insulin required *(check):*** ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Other: _____

Other insulin required at school; type _____ time _____ dose_____

**Student skills for using insulin *(check all that apply)*:**

☐ Counts carbohydrates using _____ ☐ Draws up correct insulin dose ☐ Other _____

☐ Calculates correct insulin dose ☐ Independently gives own injection ☐ Other _____

**Student needs assistant with *(list)*:** _____

### INSULIN DOSE FOR MEALS *(check either flexible or fixed box)*

☐ **FLEXIBLE Insulin Dose:** *Total dosage of insulin = insulin for meal + correction insulin dose* ☐ **See attached dose chart**

☐ Student uses ***(circle one):*** Grams or Servings of Carbohydrates

☐ Insulin/Carbohydrate ratios:

Breakfast: _____ units per _____ Carbohydrate
AM Snack: _____ units per _____ Carbohydrate
Lunch: _____ units per _____ Carbohydrate
PM Snack: _____ units per _____ Carbohydrate
Dinner: _____ units per _____ Carbohydrate

**Select Insulin Correction Method *(A, B, or C below)*:**

☐ **A. Insulin Correction Scale**
(correction dose is added to the meal dose of insulin)

Blood glucose less than _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units

☐ **FIXED Insulin Dose *(includes correction)*:**

☐ Student uses a fixed amount of ***(circle one):*** Grams or Servings of Carbohydrates

☐ Insulin for this fixed amount of carbohydrates is calculated within scale below

☐ Fixed Insulin dose required for snacks (list):_____

⬇ ⬇ ⬇

Blood glucose less than _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units
Blood glucose is_____ to _____ = _____ units

☐ **B. Calculated Correction Dose of Insulin** ☐ Rounding Rule *(list):* _____

_____ – _____ ÷ _____ = _____

Blood glucose – Target blood glucose ÷ Correction factor = Correction dose *(correction dose is added to the meal dose of insulin)*

☐ **C. Set Correction Dose_____ units per _____ mg/dL above _____ mg/dL**

### EXTRA INSULIN: NON-MEAL TIME ONLY ☐ *Not applicable*

**Criteria for giving extra insulin *(all apply):***

- Extra insulin is given if it has been more than 2 hours since last dose was given
- Blood glucose level is over _____ mg/dL
- Do not exceed 2 extra doses in one school day
- Blood glucose must be checked in 2 hours after correction dose is given
- Notify parents when extra doses are given at school
- Other: _____

**Options:** ☐ Use insulin correction scale above ***OR*** ☐ Use calculated insulin correction dose above

### INSULIN PUMP ☐ *Not applicable*

**Insulin Dose (*check one):*** ☐ Used Bolus Calculator ***OR*** ☐ Bolus dose per flexible or fixed insulin dose (see above)

**Student skills *(check one):*** ☐ Independent with pump use ☐ Requires assistance with pump use (see below)

**Student Pump Abilities/Skills *(check if needs assistance):***

☐ Bolus correct amount ☐ Calculates & sets temporary basal rate ☐ Prepare reservoir & tubing
☐ Calculates & administers correct bolus ☐ Disconnects pump ☐ Trouble shoots alarms & malfunctions
☐ Calculates & set basal profiles ☐ Reconnects pump at infusion set ☐ Other: _____

**Plan for pump failure:** _____

### SIGNATURE ADDENDUM

Student Name _____ Date of Birth _____

This page (Page 4) of the DMMP can be used to provide updates to insulin dose information as needed. Once signed and dated by the Health Care Provider, this page replaces any previous insulin dose information provided in the student's Diabetes Medical Management Plan.

**SIGNATURE** – Health Care Provider _____ Date _____

**SIGNATURE** – Parent/Guardian Approval _____ Date _____

**MEALS/SNACKS AT SCHOOL**

Student independently calculates the amount of carbohydrate in meals/snacks: ☐ Yes ☐ No

Student may eat carbohydrates as desired: ☐ Yes ☐ No (If no, indicate amounts below)

**Common Carbohydrate Amounts and Timing of Meals/Snack:**

Breakfast: _____ grams or servings at _____ Morning snack: _____ grams or servings at _____

Lunch: _____ grams or servings at _____ Afternoon snack: _____ grams or servings at _____

Dinner: _____ grams or servings at _____ Night snack _____ grams or servings at _____

**Additional snack(s) required:** ☐ Before physical activity ☐ After physical activity ☐ Other: _____

Preferred snack foods *(list):* _____

Food allergies: _____

Foods to avoid *(if any):* _____

List food options for school parties and special school events:

Option 1: _____

Option 2: _____

***Note: For Students using Insulin refer to prior Insulin section of this form.***

**PHYSICAL ACTIVITY/SPORTS**

☐ **Have fast-acting carbohydrates available at times of physical activity and sports.**

Student **should not** exercise/engage in physical activity if ketones are *(circle all that apply):* trace / small / moderate / large

Student **should not** exercise/engage in physical activity: ☐ If blood glucose is greater than _____ mg/dL

☐ If blood glucose is less than _____ mg/dL

**ALL SCHOOL-SPONSORED ACTIVITIES**

(e.g., field trips, extracurricular activities, etc.)

**Notify family of activities in order to preplan by:** ☐ 1 week ☐ 2 weeks ☐ Other: _____

**The following diabetes supplies should be available to the student during school-sponsored activities:**

- ☐ A copy of the student's Diabetes Medical Management Plan (DMMP), Section 504 Plan, Emergency Action Plan, and Healthcare Plan
- ☐ Blood glucose monitor and test strips
- ☐ CGM sensor information
- ☐ Fast-acting carbohydrate source (e.g., milk, fruit juice, glucose gel, glucose tablets)
- ☐ Injection/insulin pump supplies and insulin with appropriate storage to prevent spoilage of insulin (if using insulin)
- ☐ Bag lunch or snack (optional)
- ☐ Glucagon kit (if using insulin)
- ☐ Other: _____

I have reviewed and approved the Diabetes Medical Management Plan (DMMP). This DMMP shall remain in effect through the end of the current school year unless discontinued or changed in writing. I understand the DMMP or appropriate parts of the DMMP will be shared with relevant school personnel.

**SIGNATURE** – Health Care Provider _____ **Date** _____

**SIGNATURE** – Health Care Provider _____ **Date** _____

**SIGNATURE** – Parent/Guardian _____ **Date** _____

**SIGNATURE** – Parent/Guardian _____ **Date** _____

**Update this plan *(check all that apply):***

☐ Any time there are treatment changes ☐ 3 months ☐ 6 months ☐ Start of School year ☐ Other _____