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 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

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 ☐ Suspend insulin pump ☐ 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: _____

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

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

☐ Before physical activity/physical education
☐ During physical activity/physical education
☐ After physical activity/physical education
☐ Symptoms of high blood glucose
☐ Symptoms of low blood glucose
☐ When student is sick

CONTINUOUS GLUCOSE MONITORS (CGM)

☐ *Not applicable*

Treatment decisions and diabetes care plan adjustments should never be made based on CGM results.

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 *(check all that apply):*

☐ Any high or low glucose alert
☐ Before insulin or medication is used to lower glucose
☐ Any symptoms of low or high blood glucose
☐ Any time the CGM system is not working

Additional comments:

_____

_____

_____

SICK DAY

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

- Check blood glucose
- Check ketones
- Offer sugar-free fluids
- 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: _____

ORAL MEDICATION

☐ *Not applicable*

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

1. _____
2. _____
3. _____
4. _____

INSULIN

☐ ***Not applicable***

Insulin required and delivered by *(check)*: ☐ Syringe/Vial ☐ Pre-filled Syringe ☐ Insulin Pen ☐ Insulin Pump

Type of Insulin used:

☐ Rapid/short: Humalog / Novolog / Apidra *(circle)* ☐ Intermediate/NPH: Humulin / Novolin *(circle)*

☐ Regular: Humulin / Novolin *(circle)* ☐ Long: Glargine (Lantus) / Detemir (Levemir) *(circle)*

Insulin to be given by: ☐ Approved School Personnel ☐ Student ☐ Parent ☐ Other _____

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

☐ Counts and calculates carbohydrates ☐ Draws up correct insulin dose

☐ Determines correct insulin dose for carbohydrates consumed ☐ Gives own injection

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

Give Insulin *(check)*: ☐ Before eating (eat within 5 minutes) ☐ After eating (give insulin 10 minutes after meal)

Insulin Dose for Meals ☐ Fixed Insulin Dose **OR** ☐ Flexible Insulin Dose

- **FIXED Insulin Dose:**

_____units, if blood glucose is_____ to _____ mg/dL _____units, if blood glucose is_____ to _____ mg/dL

_____units, if blood glucose is_____ to _____ mg/dL _____units, if blood glucose is_____ to _____ mg/dL

_____units, if blood glucose is_____ to _____ mg/dL _____units, if blood glucose is_____ to _____ mg/dL

- **FLEXIBLE Insulin Dose:** *(Total dosage of insulin = insulin for food + correction insulin dose)*:

☐ _____units per carbohydrate serving **OR** ☐ 1 unit for _____ grams of carbohydrate

A standard insulin correction dose is _____ units per _____ mg/dL above _____ mg/dL

Insulin Correction Scale:

_____units, if blood glucose is_____ to _____ mg/dL _____units, if blood glucose is_____ to _____ mg/dL

_____units, if blood glucose is_____ to _____ mg/dL _____units, if blood glucose is_____ to _____ mg/dL

_____units, if blood glucose is_____ to _____ mg/dL _____units, if blood glucose is_____ to _____ mg/dL

Insulin for Correction: Non Meal Time ☐ Not applicable ☐ Applicable *(see options and criteria below):*

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

Criteria for giving extra insulin for correction *(check all that apply):*

☐ Extra insulin is given if it has been more than 2 hours since last dose was given and it is not a meal

☐ Blood glucose must be checked in 2 hours after correction dose is given

☐ Blood glucose level is over _____ mg/dL

☐ Notify parents when extra doses are given at school

☐ Do not exceed 2 extra doses in one school day

☐ Other _____

Insulin Pump: ☐ Not applicable ☐ Applicable *(continue below)*

Insulin for Pump: ☐ Used Bolus Calculator **OR** ☐ Bolus dosage as indicated below

Breakfast: _____ units/gram Afternoon snack: _____ units/gram

Morning snack: _____ units/gram Dinner: _____ units/gram

Lunch: _____ units/gram Evening snack: _____ units/gram

Student pump abilities/skills *(check all that apply)*:

☐ Counts and calculates carbohydrates

☐ Boluses correct amount for carbohydrate consumed

☐ Changes infusion set/prepares reservoir and tubing

☐ Inserts new infusion set

☐ Disconnects pump

☐ Reconnects pump infusion set

☐ Performs temporary basal changes

☐ Troubleshoots alarms or malfunctions

Student may disconnect insulin pump during *(check all that apply)*: ☐ Vigorous sports ☐ Shower ☐ Other _____

☐ **If insulin pump fails for any reason, call parents/guardians/healthcare provider *(see insulin correction dose above)***

SIGNATURE ADDENDUM

This is an addendum to the original Diabetes Medical Management Plan. The changes listed above for the Insulin and Insulin Pump sections replaces any previous information.

SIGNATURE – Heath Care Provider _____ Date _____

SIGNATURE – Parent/Guardian _____ 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 at _____ am Morning snack: _____ grams at _____ am/pm

Lunch: _____ grams at _____ am/pm Afternoon snack: _____ grams at _____ pm

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 _____

Clear Form