**DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
F-43013 (Rev. 06/16)

**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** **TREAT IF blood sugar is less than ________ mg/dL** *(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
☐ Determines correct insulin dose for carbohydrates consumed
☐ Draws up correct insulin dose
☐ 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 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 ______________________________________

**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 ________