City of St. Charles R-6 School District
400 North Sixth Street, St. Charles, MO 63301
Diabetes Medical Management Plan (DMMP)

Building: _____ Phone: _____

Contact: _____ Fax: _____

Notice to Parents: Medication(s) **MUST** be brought to school by the PARENT/GUARDIAN in a container that is appropriately labeled by the pharmacy.

In order for schools to safely administer medication during school hours, the following guidelines should be observed:

- A new copy of the DMMP must be completed at the beginning of each school year. This form or a Prescription Medication form must be received in order to change diabetes care at school during the school year.

Student Name (Last, First, MI)	Date of Birth:	Grade:
Student's Diagnosis: **DIABETES:** ☐**Type 1** ☐**Type 2** ☐ **Other**		
Parent Name:	1st Contact #:	2nd Contact #:
Home Address:	City:	State, Zip Code
Emergency Contact:	Phone:	
Emergency Contact:	Phone:	

MONITORING		
BLOOD GLUCOSE (BG) MONITORING with meter, lancets, lancing device, and test strips	☐ Yes ☐ No ☐ Student requires supervision ☐ To be performed by school personnel ☐ Student is independent ☐ Permission to self-carry	☐ Before meals ☐ For symptoms of hypo/hyperglycemia & anytime the student does not feel well ☐ Before PE/Activity ☐ After PE/Activity ☐ Prior to dismissal ☐ Additional BG monitoring may be performed at parent's request
CONTINUOUS GLUCOSE MONITORING (CGM) **Brand/Model:** _____	☐ Yes ☐ No Alarms set for: Low: _____ (mg/dL) High: _____ (mg/dL)	Always confirm CGM results with finger stick. Check before taking action on sensor BG level. If student has symptoms or signs of hypoglycemia, check finger stick BG level regardless of CGM.
☐ **URINE KETONE TESTING** ☐ **BLOOD KETONE TESTING**	Anytime the **BG >_____** mg/dL or when student complains of nausea, vomiting, or abdominal pain. See pg. 3 for further instruction under hyperglycemia management.	

NAMEOF MEDICATION	**DOSE/ROUTE**	**TIME**
☐ **GLUCAGON** - INJECTABLE	☐ 0.5 mg subq/IM ☐ 1.0 mg subq/IM	Immediately for severe hypoglycemia; unconscious, semi-conscious (unable to control his/her airway or unable to swallow), or seizing

ORAL MEDICATIONS	**DOSAGE**	**TIME**	**POSSIBLE SIDE EFFECTS**	**TREATMENT SIDE EFFECTS**
☐Glucophage® (Metformin) ☐ to be administered at school	_____mg po	___ AM or PM	Nausea/vomiting, diarrhea	Clear liquids
☐Other: ☐ to be administered at school	_____mg po			
☐Additional Instructions:				

School Year:	Physician Signature: Printed Name:	Office Phone: _____ Office Fax: _____ **Emergency #:**_____

DIABETES MEDICAL MANAGEMENT PLAN (DMMP)

Student:_____

Effective Date:_____

INSULIN	
Insulin to be given during school hours ☐ Yes ☐ No	☐ Student can administer insulin if supervised ☐ Student can administer his/her own insulin ☐ Student can not administer insulin
Insulin Types: ☐ Rapid-acting Insuln Type: _____ ☐ Short-acting Insulin Type: **Regular** ☐ Intermediate-acting Insulin Type: **NPH** ☐ may mix with rapid or short-acting insulin ☐ Long-acting Insulin Type: _____ _____ units at ____AM or PM ☐ may mix with rapid or short-acting insulin *(all doses to be administered subcutaneously)*	☐ **Meal Plan:** ☐ according to the following distribution: Breakfast: ____ grams AM Snack: ____ grams Lunch: ____ grams PM Snack: ____ grams ☐ Insulin: CHO Ratio: 1 unit for every ____ grams of CHO ☐ Decrease by 1 unit if pre-lunch reading is less than 80 mg/dL or if strenuous exercise is anticipated.
☐ Pre-breakfast dose: Regular ____ units Humalog® or Novolog® or Apidra® ____ units NPH ____ units ☐ Pre-lunch dose: Regular ____ units Humalog® or Novolog® or Apidra® ____ units NPH ____ units ☐ Pre-dinner dose: Regular ____ units Humalog® or Novolog® or Apidra® ____ units NPH ____ units	
☐ **Sliding scale to be administered at _____ (times)** If BG Units of rapid-acting insulin subq _____ give _____ _____ give _____ _____ give _____ _____ give _____ _____ give _____ _____ give _____	☐ **Insulin Sensitivity (Correction Factor) to be administer at _____ (times)** ☐ The predicted drop in BG concentration after administration of 1 unit of regular or rapid-acting insulin usually expressed as "1 unit for every ____ mg/dL BG is > target" ☐ If uneven, then round to the nearest **half or whole unit**. May use clinic discretion: if physical activity follows meal, then may round down. Sensitivity: _____ Target: _____
Other Instructions:	

Snacks

- Children using NPH insulin usually require snacks without additional insulin coverage (please, adhere to CHO amounts ordered above)
- Scheduled snacks may be required prior to or after exercise in order to prevent hypoglycemia. Insulin is not administered with these snacks

☐ Before Exercise ☐ After Exercise

- Foods may be eaten at unscheduled times. Insulin may be ordered for these snacks in order to prevent post-meal hyperglycemia (see above).
- Snack time insulin = # CHO consumed/CHO Ratio
- Never provide insulin coverage for CHO/glucose being used to treat hypoglycemia

Exercise and Sports

- In general, there are no restrictions on activity unless specified
- A student should not exercise if his/her BG is <100 mg/dL or > 300 mg/dL and ketones are positive
- A source of fast-acting glucose & glucagon (if ordered) should be available in case of hypoglycemia

School Year:	Physician Signature: Printed Name:	Office Phone: _____ Office Fax: _____ **Emergency #:**_____

DIABETES MEDICAL MANAGEMENT PLAN (DMMP)

Student:_____

Effective Date:_____

Hypoglycemia (Low BG)

Hypoglycemia is defined as BG < _____ mg/dL

Signs of hypoglycemia:

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatigue	Fighting	Crying
Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure

- If hypoglycemia is suspected, check the BG level

Hypoglycemia Management (Low Blood Glucose)	**Severe Hypoglycemia: If student is unconscious, semi-conscious (unable to control his/her airway or unable to swallow) or seizing, administer glucagon** • Place student in the "recovery position" • If glucagon is administered, call 911 then call Parent/Legal Guardian
	Mild or Moderate Hypoglycemia: If conscious and able to swallow, immediately give 15 grams of fast-acting glucose: • 3-4 glucose tablets or • 6 Life Saver® candies or • 4 ounces of regular soda/juice or • 1 small tube of Glucose/cake gel
	Repeat BG check in 15 minutes • If BG still low, then re-treat with 15 gram CHO • If BG in acceptable range and at lunch or snack time, let student eat and cover CHO per orders • If BG in acceptable range and not lunch or snack time, provide student slowly-released CHO snack (Example: 3-4 peanut butter or cheese crackers or ½ sandwich
	In unable to raise the BG > 70 mg/dL despite fast-acting glucose sources, call _____

Hyperglycemia (High BG)

Hyperglycemia is defined as BG > _____ mg/dL

Signs of hyperglycemia:

Extreme thirst	Frequent urination	Blurry vision	Hunger	Headache
Nausea	Hyperactivity	Dry skin	Dizziness	Stomach ache

- If hyperglycemia is suspected, check the BG level

Hyperglycemia Management (High Blood Glucose)	**If BG > 300 mg/dL, or when child complains of nausea, vomiting, and/or abdominal pain, ask the student to check his/her urine for ketones**
	• If urine ketones are trace to small (blood ketones 0 – 1.0 mmol/mL), give 8-16 ounces of sugar free fluid (water), return to classroom • If correction insulin has not been administered within 3 hours, provide correction insulin according to student's Correction Factor and Target pre-meal BG • Recheck BG and ketones 2 hours after administering insulin
	• If urine ketones are moderate/large (blood ketones > 1.0 mmol/L), give 8-16 ounces of sugar-free fluid (water) and call _____ for instructions concerning insulin administration • Contact the Parent/Legal Guardian • Recheck BG and ketones 2 hours after administering insulin

I request that the St. Charles School District's designated personnel administer the above medicine to my child. I also give permission for the authorized prescriber to release the required information for safe administration of this medicine at school. I understand that the nurse has the right to question any medication order he/she deems potentially inappropriate, and to verify the validity of any medication order. I also understand that it is the right of the nurse to refuse to give any medicine that he/she feels does not meet the criteria established by Nursing Procedure and the St. Charles School District.

School plan ordered by:	Physician Signature: Provider Printed Name:	Date:
Acknowledged and received by	Parent/Legal Guardian:	Date:
Acknowledged and received by	School Nurse:	Date: