ARISTOTLE

PREPARATORY ACADEMY

Diabetic Medical Management Plan (DMMP)

This plan should be completed by the student's personal health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be easily accessed by the school nurse or other trained diabetes personnel. It is the parent/guardian's responsibility to update any changes in the student's plan.

Date of Plan: _____ (This plan will be valid for one year) Campus: _____

Student's Information

Student's Name: _____ Date of Birth: _____ Grade: _____

Date of Diagnosis: _____ ☐ Type 1 ☐ Type 2 ☐ Other: _____

Parent/Guardian Name: _____ Phone Number(s): _____

Emergency Contact: _____ Phone Number: _____

Relationship to student: _____

Health Care Provider Information

Provider Name: _____ Phone Number: _____

Address: _____

This Diabetes Medical Management Plan has been completed and/or approved by:

Provider Signature: _____ Date: _____

(Please read all the way to the end and initial on page 6 as appropriate)

Medication and Equipment

Medication: _____ Dose: _____ Route: _____ Time/Frequency: _____

Medication: _____ Dose: _____ Route: _____ Time/Frequency: _____

Medication: _____ Dose: _____ Route: _____ Time/Frequency: _____

Continuous Glucose Monitor (CGM): ☐ **Yes** ☐ **No** Used for Dosing: ☐ **Yes** ☐ **No**

Brand/Model: _____ Student uses independently: ☐ **Yes** ☐ **No**

Glucose Meter: ☐ **Yes** ☐ **No** Brand/Model: _____ Student uses independently: ☐ **Yes** ☐ **No**

Pump: ☐ **Yes** ☐ **No** Brand/Model: _____ Student uses independently: ☐ **Yes** ☐ **No**

Basal rate: ☐ **Yes** ☐ **No** ***If yes***: ____:____ - ____:____ Basal Rate: _____

____:____ - ____:____ Basal Rate: _____

Type of Infusion set: _____ Appropriate Sites: _____

ARISTOTLE

PREPARATORY ACADEMY

Blood Glucose Monitoring

Target Range of Blood Glucose: _____ - _____

Check Blood Glucose:

☐ Before Breakfast ☐ After Breakfast

☐ Before Lunch ☐ After Lunch

☐ Before PE ☐ After PE ☐ As needed for signs/symptoms of illness

☐ 2 hours after a correction dose ☐ As needed for signs/symptoms of low or high blood glucose

☐ Other: _____

Student's Checking Skills (*Check One)*

	Independently checks own blood glucose
	Supervised checks of own blood glucose
	Staff to perform blood glucose checks

Student should be <u>escorted</u> to the Health Office if blood sugar is:

Less than: _____ **or** Greater than: _____

Continuous Glucose Monitor (CGM)

Alarms set for: Severe Low: _____ Low: _____ High: _____

Predictive Alarm: Low: _____ High: _____ Rate Change/Suspend: Low: _____ High: _____

- Confirm CGM results with a hard stick before giving insulin *(unless student is approved for dosing off CGM)*
- If student has signs/symptoms of hypoglycemia, check fingertip glucose regardless of CGM.
- Insulin injections should be given at least three inches away from the CGM site.
- Do not disconnect the CGM for any reason
- If the adhesive is peeling, reinforce it with approved medical tape
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw away any pieces.

Student CGM Skills	Independently	
	Yes	No
Troubleshoots alarms and malfunctions		
Knows how to respond to a HIGH alarm		
Knows how to respond to a LOW alarm		
Can Calibrate the CGM		
Knows how to respond to blood glucose trend indications		
Changes CGM site		

ARISTOTLE

PREPARATORY ACADEMY

Insulin Therapy

Main Insulin Delivery Type: ☐ Pump ☐ Pen ☐ Syringe

Secondary(backup) Insulin Delivery Type: ☐ Pen ☐ Syringe Location: _____

Bolus Insulin Therapy

Name of Fast-acting Insulin to be used at school: _____

When to give Insulin (check all that apply)**:**

Breakfast

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus Correction dose when blood glucose is greater than _____ and at least _____ hours since last insulin dose.

Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus Correction dose when blood glucose is greater than _____ and at least _____ hours since last insulin dose.

Snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus Correction dose when blood glucose is greater than _____ and at least _____ hours since last insulin dose.

Other:

☐ Correction Dose only Details: _____

Carbohydrate Coverage	Correction Dose
Insulin-to-Carbohydrate Ratio: Breakfast: **1** unit of insulin per _____ grams of carbs Lunch: **1** unit of insulin per _____ grams of carbs Snack: **1** unit of insulin per _____ grams of carbs	**Correction Factor (Insulin Sensitivity Factor):** _____ **Target Blood Glucose (BG):** _____
Calculation: **Total grams of Carbohydrate eaten** / **Insulin-to-Carbohydrate Ratio** = **Units of Insulin**	**Calculation:** **Current BG – Target BG** / **Correction Factor** = **Units of Insulin**

ARISTOTLE

PREPARATORY ACADEMY

Insulin Therapy (cont.)

Call parents if:

BS is less than _____
BS is greater than _____
Suspected or actual pump failure

Student's Insulin Administration Skills (*Check One)*

	Independently calculates and gives own injections
	Supervised calculations and injections
	Staff to calculate dose and student to give own injection
	Staff to calculate dose and student to give injection with supervision
	Staff to calculate dose and give injection

Pumps

For blood glucose greater than _____ that has not decrease within _____ hours after correction, consider pump failure.

☐ For infusion site/pump failure, give insulin via secondary method as described on page 3

☐ Student may disconnect pump for: ☐ Physical Activity ☐ Other: _____ for no more than ____ hours

Student Pump Skills	Independently	
	Yes	No
Administers correct bolus		
0Sets or adjusts basal rates		
Changes batteries		
Disconnects pump		
Reconnects pump to infusion set		
Prepares reservoir, pod and/or tubing		
Inserts infusion set		
Troubleshoots alarms and malfunctions		

Nutrition

☐ Student will eat breakfast at school and will require correction dose

Special party/event food may be provided to the class at times, student may have this food at the:

☐ Students discretion ☐ Parent/Guardian's discretion ☐ Student may <u>not</u> partake

Physical Activity

☐ The following quick acting glucose must be available at the site of physical education activities and sports

☐ Glucose tablets ☐ Sugar containing juice ☐ Other: _____

Student should eat ☐ 15grams ☐ 30grams ☐ Other: _____grams of carbohydrate

☐ Before ☐ every 30 minutes during ☐ Every 60 minutes during ☐ After vigorous physical activity

If most recent blood glucose is less than _____, student can participate in physical activity when blood glucose is corrected and above _____.

Avoid physical activity when blood glucose is greater than _____ or if urine/blood ketones are moderate to large.

ARISTOTLE

PREPARATORY ACADEMY

Hypoglycemia (Low Blood Glucose) Treatment

Student's usual symptoms of hypoglycemia:

☐ Hunger ☐ Sweating ☐ Trembling ☐ Pale Skin ☐ Inability to Concentrate ☐ Confusion

☐ Irritability ☐ Sleepiness ☐ Headache ☐ Dizziness ☐ Slurred Speech ☐ Poor Coordination

☐ Other: _____

If exhibiting any of these symptoms, OR if blood glucose level is less than _____, give a quick-acting glucose product equal to _____grams of carbohydrate.

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose is less than _____.

Additional Treatment: _____

If the student is unable to eat or drink, is unconscious or unresponsive, or having seizure activity or convulsions:

- Position the student on his or her side to prevent choking
- Do not attempt to put anything in their mouth
- Do not hold them down or restrict movement when seizing
- Give Glucagon: ☐ 1mg ☐ 0.5mg ☐ Other dose: _____
  ☐ Subcutaneous (SQ) ☐ Intramuscular (IM)
  Preferred site: ☐ Buttocks Arm Thigh Other: _____
- Give Baqsimi: ☐ 3mg ☐ Other dose: _____ ☐ Intranasal Use Only
- Call 911 and then the student's parents/guardians

Do not leave student alone or allow to leave class alone if their blood glucose is less than _____

Hyperglycemia (High Blood Glucose) Treatment

Student's usual symptoms of hypoglycemia:

☐ Extreme/Excessive Thirst ☐ Sleepiness ☐ Inability to Concentrate ☐ Blurred Vision

☐ Frequent Urination ☐ Headache ☐ Nausea ☐ Vomiting ☐ Confusion

☐ Other: _____

Encourage Fluids!

Ketones:

Check via: ☐ Urine ☐ Blood every _____ hours when blood glucose is greater than _____.

Additional Treatment for Ketones: _____

✦ Allow unrestricted access to the bathroom and water

If the student has symptoms of a hyperglycemia emergency, call 911 and contact the student's parents/guardians. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing fatigue or lethargy and/or decreased level of consciousness.

ARISTOTLE

PREPARATORY ACADEMY

Disaster Plan

☐ To prepare for an unplanned disaster or emergency, parents/guardians will provide a 72-hour emergency supply kit

☐ Continue to follow orders contained in this DMMP

☐ Additional orders as follows (ex. Dinner and nighttime): _____

_____

☐ Other: _____

To Be completed by the Medical Provider:

The parents/guardians are authorized to adjust as follows (check all that apply):

☐ Increase or Decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate ***Initals:_____***

☐ Increase or Decrease correction dose scale within the following range: +/- _____ units of insulin ***Initals:_____***

☐ Parents/guardians may NOT make adjustments without a providers order ***Initals:_____***

Signatures

I (parent/guardian) _____, give permission to the school Health Aide or another qualified health care professional or trained diabetes personnel of Aristotle Preparatory Academy to perform and carry out the diabetes care tasks as outlined in (student) _____'s Diabetes Medical Management Plan (DMMP). I also consent to the release of the information contained in this DMMP to all school staff members and other adults who have a 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 Health Aide or another qualified health care professional to contact my child's physician/healthcare provider to verify and obtain information.

Acknowledged and received by:

Student's Parent/Guardian Date

_____

Student's Parent/Guardian Date

_____

Health Aide/District Nurse Date

_____

ARISTOTLE

PREPARATORY ACADEMY

Daily Schedule

	Evaluation	Action
Event: Time:	Less than:	Call parents/guardians Never leave alone Give _____ grams of fast acting sugar
	–	
	–	
	Greater than:	Call parents/guardians Encourage water or other non-sugary fluids
Event: **Lunch** Time:	Less than:	Call parents/guardians Never leave alone Give _____ grams of fast acting sugar
	–	
	–	
	Greater than:	Call parents/guardians Encourage water or other non-sugary fluids
Event: **Snack** Time:	Less than:	Call parents/guardians Never leave alone Give _____ grams of fast acting sugar
	–	
	–	
	Greater than:	Call parents/guardians Encourage water or other non-sugary fluids

ARISTOTLE

PREPARATORY ACADEMY

DIABETIC EMERGENCY CARE PLAN FOR THE BUS DRIVER

CAMPUS: _____ SCHOOL YEAR: 20_____ /20_____

STUDENT NAME: _____ CARRIES SUPPLIES: ___YES ____ NO

(SUPPLIES SHOULD INCLUDE: GLUCOMETER, FAST ACTING SUGAR OR GLUCOSE TABLETS)

BUS # _____ ROUTE # _____ GRADE: _____ TEACHER: _____

PARENT/GUARDIAN NAME: _____

PHONE #: _____ CELL #: _____

PRESENTING PROBLEM INFORMATION:

LOW BLOOD SUGAR (DIABETES)

Student may be hungry, sweating, have a headache, appear fussy or cranky.

EMERGENCY PLAN:

1. **STOP** the bus.
2. Check their blood sugar with glucometer if available. If glucometer is not available, and student is able to swallow, treat with sugar anyway.
3. Look in backpack for a source of sugar.
4. If awake, give juice, regular soda (not diet), 4 glucose tablets (provided by parent), or another source of sugar right away.
5. Wait 15 min then recheck blood sugar, if still low, give another source of sugar. Call parent and school to notify of situation.
6. Call 911 if student does not respond or is having a seizure.
7. Report incident to school and parent.
8. Other Instructions: _____

_____

Parent Signature Parent Printed Name Date

ARISTOTLE

PREPARATORY ACADEMY

Letter to Parent Regarding Administration of Medication in School

Dear Parent:

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type, including over the counter drugs given during school hours, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form ***(Request for Medication Administration in School)*** from the school nurse or school secretary. Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed by the physician for both prescription and over the counter drugs, the form must be signed by the doctor and by you, the parent or guardian. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over the counter drugs must be received in the original container, labeled with your child's name, and will be administered according to the doctor's written instructions.
   (Please see and sign page 2, Parent/Guardian responsibilities)
3. You may discuss with your doctor an alternative schedule for administering medication (i.e. outside of school hours)
4. Self-Medication: In accordance with G.S. 115C-375.2 and G. S. 115C-47, students requiring medication for asthma, anaphylactic reactions (or both), and diabetes may self-medicate with physician authorization, parent permission and a student agreement for self-carried medication. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for and management of self-carry medications.

School personnel will not administer any medication to the students unless they have received a medication form properly completed and signed by both doctor and parent/guardian, and the medication has been received in an appropriately labeled container. If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school nurse at the following number: _____.

Thank you for your cooperation,

_____

School Nurse Date

_____

Director Date

ARISTOTLE

PREPARATORY ACADEMY

The Responsibility of the Parent or Legal Guardian

1. Limit the medications that must be given during the school day to those necessary in order to maintain the child at school.
2. Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form (Request for Medication Administration in School). Return completed form to school. A separate parent request/permission form must be completed for each medication given at school.

3. Complete an Authorization form, signed by a health care provider licensed to prescribe medications, which includes the following:
    a. Name of child
    b. Name of medication
    c. Date it was prescribed
    d. Dosage
    e. How the medicine is to be given at school
    f. When the medicine will be given at school
    g. Special instructions about the child receiving the medication or about the medicine itself.
    h. Until what date the medicine is to be given at school
    i. Possible side effects of the medication
    j. Possible adverse reactions to the medication
    k. Name of the health care provider and how to locate or communicate with him or her if necessary
4. Provide each medication in a separate pharmacy-labeled container that includes the child's name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication.

    Note: The parent should request of the pharmacist to provide two labeled containers – one for home use and one for school use – if child needs to be given medication both at home and at school.

5. Over the counter medications administered at school should be provided in their original packaging labeled with the student's name.
6. Provide the school with new, labeled containers when dosage or medication changes are prescribed.
7. Retrieve all unused medications from school when medications are discontinued, and /or at end of school year (according to local written policy)
8. Maintain communication with the school staff regarding any changes in the medical treatment needed at school.

_____

Parent Signature Date

_____

Health Office Representative Date

ARISTOTLE

PREPARATORY ACADEMY

Request for Medication Administration in School

To be completed by physician

Name of Student: _____

School: _____

Medication: (each medication is to be listed on a separate form) _____

Dosage and Route: _____

Time(s) medication is to be given: a.m.: _____ p.m.: _____ PRN: _____

Note: Medication will be given as close to prescribed time as possible but may be given up to one hour before or after prescribed time. Please advise if there is a time specific concern regarding administration.

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.): _____

_____

Contraindications to administration: _____

Physician *(printed)* **Name**: _____ Address: _____

Physician Contact Information: Phone: _____ Fax:_____

Physician's Signature: _____ Date: _____

**This form is invalid unless stamped and signed by the healthcare provider*

Physician's Stamp Here

I hereby give permission for my child (named above) to receive medication during school hours; administered by the health aide or director appointed staff. The medication will be furnished by me in the original container, labeled with the child's name and is to be given as stated above. I understand that medication will NOT be accepted if brought in by my child or is loose in a baggie, envelope or other container. I will count the medication with the staff and co-sign off on the medication. I give my consent to Aristotle Preparatory Academy to contact the prescribing physician and exchange relevant medical information to clarify this medication order. I hereby release the School Board and their agents and employees from all liability that may result from my child taking this medication.

Parent/Guardian signature _____Date: _____

Please document medication count ***with parent present*** below:

Date	Medication Name	Count	Expiration Date	Parent signature	Employee initials

ARISTOTLE

PREPARATORY ACADEMY

Medication Administration Record

Student Name: _____ **Medication:** _____

A separate sheet is used for each medication or treatment

Key: A=Absent FT= Field Trip NS= No Show NM= No Medication in office RF= Refused ED= Early

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										

Additional Daily Administrations (PRN Meds only):

Date	Time	Person Administering (Name & Initials)

ARISTOTLE

PREPARATORY ACADEMY

Student Agreement for Self-Carried Medication

Student: _____Grade: _____ Campus: _____
Parent(s) Printed name: _____
Parent(s) Contact Numbers: _____
Health Care Provider: _____Phone Number: _____
Medication: _____ Dose and Time: _____

FOR PROVIDER

□ Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions only.

Asthma ___ MDI (Metered Dose Inhaler) ___MDI with spacer____

Allergic reaction _____ Epinephrine ____ Auvi-Q _____

Diabetes ____ Insulin ____ Glucose ____

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C-375.2 The student also must have this self-medication agreement on file. The students name must appear on medications and devices.

*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency and that will be replaced when it expires.

Student Responsibilities

- *I will keep my inhaler/equipment, Epinephrine Auto Injector, or diabetes medication/equipment with me at school.*
- *I agree to use my inhaler/equipment, Epinephrine Auto-Injector, or diabetes medication/equipment in a responsible manner, in accordance with my licensed health care providers' orders.*
- *I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition*
- *I will not allow any other person to use my medication or equipment.*

Student Signature: _____Date: _____

___Emergency Action Plan complete and on file at school
___Demonstrates correct use/administration
___Verbalizes proper and prescribed timing for medication
___Agrees to carry medication
___Can describe own health condition well
___Keeps a second labeled container in health office or main office
___Will not share medication or equipment with others

As the parent/guardian of the above-named student, I acknowledge that Aristotle Preparatory Academy, its employees, or agents shall incur no liability as a result of any injury arising from the self-administration or misuse of the above-named medication by the above-named student; or if the above named-student does not have the medication with them when needed; or if the medication carried by the above-named student has passed its expiration date. I agree to hold harmless the school and its employees or agents against any claims arising out of such self-administration.

Parent Signature: _____Date: _____

School Nurse Signature: _____ Date: _____

Director Signature: _____ Date: _____

Physician Signature: _____ Date: _____