American Diabetes Association.

Safe at School®

Diabetes Medical Management Plan

202 - 202

(Add student photo here.)

TABLE OF CONTENTS

PARENT/GUARDIAN RED SECTIONS	PAGE	SECTION
Demographics	1	1
Supplies/Disaster Plan/Field Trips	1	2

HEALTHCARE PROVIDER BLACK SECTIONS	PAGE	SECTION
Required Supervision at School	2	3
Blood Glucose Monitoring	2	4
Insulin Delivery Devices	2	5
Insulins and Diabetes Meds	2	6
Insulin Timing	2	7
Dosing Table (Single-Page Update)	3	8
Low Blood Glucose Management	4	9
High Blood Glucose Management	5	10
Approval Signatures	5	-

Student Last Name: First Name: DOB:

School Name: School Phone #: School Fax #: Grade:

Home Room: School Point of Contact Name and Email Address: Contact Phone #:

1. DEMOGRAPHIC INFORMATION—(PARENT/GUARDIAN)

Please complete page 1 of the DMMP and submit form to your healthcare provider prior to the start of school.

Student's Cell #: Diabetes Type: Date Diagnosed: Month: Year:

STUDENT'S SCHEDULE Arrival Time: Dismissal Time:

Travels to school by (check all that apply):
- ☐ Foot/Bicycle
- ☐ Car
- ☐ Bus
- ☐ Attends Before-School Program

Meal Times:
- ☐ Breakfast
- ☐ AM Snack
- ☐ Lunch
- ☐ PM Snack
- ☐ Pre-Dismissal Snack

Physical Activity Days/Times:
- ☐ Gym
- ☐ Recess
- ☐ Sports
- ☐ Additional information:

Travels to:
- ☐ Home ☐ After-School Program
- ☐ Other
- Via: ☐ Foot/Bicycle ☐ Car ☐ Student Driver ☐ Bus

Parent/Guardian #1 (contact first): Relationship:

Cell #: Home #: Work #:

Email Address:

Indicate Preferred Contact Method:

Parent/Guardian #2: Relationship:

Cell #: Home #: Work #:

Email Address:

Indicate Preferred Contact Method:

2. PROVIDE NECESSARY SUPPLIES / DISASTER PLANNING / EXTENDED FIELD TRIPS

1. Provide a three day minimum of the following diabetes management supplies for the care of your child at school.

- Insulin
- Syringe/pen needles
- Ketone strips
- Treatment for lows and additional snacks
- Glucagon
- Antiseptic wipes
- Blood glucose meter (BGM) with test strips, lancets, extra battery – also required for all Continuous glucose monitor (CGM) users
- Insulin pump supplies (infusion set, cartridge, extra battery/charging cord) if applicable
- Additional supplies:

List self-carry supplies:

2. Review expiration dates and quantities monthly and replace items prior to expiration dates

3. View disaster/emergency planning details. Refer to Safe at School guide

4. In the event of a disaster or extended field trip, a school nurse or other designated personnel will take the student's diabetes supplies and medications to the student's location.

Has your child lost consciousness, experienced a seizure, or required glucagon in the last two years: ☐ No ☐ Yes If yes, date of last event

Has your child experienced DKA or hospitalization for diabetes in the last two years: ☐ No ☐ Yes If yes, date of last event

Name of Healthcare Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

Diabetes Medical Management Plan 202 - 202

STUDENT LAST NAME: FIRST NAME: DOB:

PROVIDERS: Please complete pages 2–5 of the form and forward completed and signed form to the school.

3. REQUIRED SUPERVISION AT SCHOOL (DEFINITIONS BELOW)

		Full Support	Supervision	Self-Care
Blood Glucose Monitoring:	Blood glucose meter (BGM) testing, responds to CGM alarms, interprets and notifies staff of readings	☐	☐	☐
Blood Glucose Management:	Low and high blood glucose management	☐	☐	☐
Insulin Administration:	Counts carbohydrates/determines meal amount, calculates insulin dose, administers insulin via syringe/pen/insulin pump, and responds to device alarms	☐	☐	☐

Self-Carry Diabetes Supplies: ☐ Yes ☐ No Smart Phone Is Medically Necessary: ☐ Yes ☐ No

Full Support: All care to be performed by school nurse and trained staff (as permitted by state law).
Supervision: Trained staff to assist and supervise. Guide and encourage independence.
Self-Care: Manages indicated diabetes skills independently. Support in the health office or classroom provided upon request and as needed.

4. GLUCOSE MONITORING AT SCHOOL

Monitor Blood Glucose: ☐ Before Meals (Default) ☐ With Physical Complaints/Illness (default, Include Ketone Testing)
☐ High or Low Blood Glucose Symptoms ☐ Before/After Physical Activity ☐ Before Leaving School ☐ Other:

CONTINUOUS GLUCOSE MONITORING (CGM) ☐ **N/A**
Brand and Model:
Remote monitoring of the CGM by the school nurse/trained school staff is ☐ optional ☐ medically necessary

Perform fingerstick if:
- Symptoms do not match the sensor reading
- Sensor reading is unavailable or tracing is inconsistent
- Sensor is still reading below 70 mg/dL 15 minutes following low treatment
- Indicated by the manufacturer recommendations

5. INSULIN DELIVERY/DOSE CALCULATION DEVICES (SELECT ALL THAT APPLY)

☐ Multiple daily injections (MDI) ☐ Insulin pump (Specify Brand and Model) ☐ Bolus Calculator App
☐ Insulin syringe ☐ Insulin pen ☐ Insulin pump is an automated insulin delivery (AID) system ☐ Investigational device
☐ Smart pen ☐ Insulin pump is an open-sourced (OS-AID) system ☐ Investigational drug
☐ Injection via i-Port ☐ Insulin inhaler ☐ Other

6. INSULINS AND OTHER GLUCOSE LOWERING MEDICATIONS

	Time, Dose, & Frequency	Route	Indication
Rapid-Acting Insulin: ☐ Novolog (Aspart) ☐ Kirsty (Aspart-xjhz) ☐ Humalog/Admelog (Lispro) ☐ Apidra (Glulisine) **Ultra-Rapid Acting Insulin:** ☐ Lyumjev (Lispro-aabc) ☐ Fiasp (Aspart) ☐ Afrezza (insulin human) inhalation powder (see addenda for inhaled dosing instructions) **Short-Acting Insulin:** ☐ Humulin R ☐ Novolin R	(see Dosing Page for details)	☐ Subcutaneous ☐ Oral inhalation ☐ Other	Administer for food and/or correction.

	Time	Dose	Frequency	Route	Indication
Long-Acting Insulin ☐ Lantus, Basaglar, Semglee, Resvoglar (Glargine) **Ultra-Long Acting-Insulin** ☐ Toujeo U-300 (Glargine) ☐ Tresiba (Degludec)	AM PM	Units Units		Subcutaneous	☐ Routine school dose ☐ Overnight field trip dose ☐ Disaster/emergency dose ☐ Pump failure

7. SUBCUTANEOUS INSULIN TIMING GUIDELINES (SELECT ALL THAT APPLY)

Insulin Administration Guidelines
Insulin Delivery Timing:
Ensure substitution carbohydrates are consumed when student does not complete their meal.

☐ **Prior to meal:** Recommended 10–15 minutes for rapid-acting insulin.
☐ **At the time of the meal:** Recommended for students using ultra-rapid insulin or the iLet insulin pump.
☐ **May advance:** Administer insulin prior to meal when student demonstrates consistent eating patterns.
☐ **Partial dose prior to meal:** Recommended for unpredictable eating, using pumps. Calculate pre-meal dose using grams of carbohydrates Follow pre-meal dose for additional grams of carbohydrate consumed, within 20 minutes (active AID: additional carbs N/A if ≥ 30 minutes late)
☐ **After meal as soon as possible:** Recommended for students that refuse food on pumps or unpredictable eating, using MDI. For MDI calculate dose based on pre-meal glucose, carbs consumed, and administer dose following meal. Pumps give correction before eating and enter grams of carbs consumed within 30 minutes of start of meal.

Name of Healthcare Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

Diabetes Medical Management Plan 202 - 202

STUDENT LAST NAME: FIRST NAME: DOB:

8. SUBCUTANEOUS INSULIN DOSING TABLE — HEALTHCARE PROVIDER TO COMPLETE – SINGLE PAGE UPDATE ORDER FORM

Add Food Dose (Table A) + Correction Dose (Table B) = Meal Dose ☐ Dosing to be determined by bolus calculator

Food Dose (Table A)

Meal or Start/End Time (HR:MIN) ☐ N/A	Carb Ratio (Formula) ☐ N/A [Grams of Carbohydrate / Carb Ratio] = Food Dose	Fixed Meal Dose ☐ Units ☐ Grams ☐ N/A ☐ N/A ☐ N/A
☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner	1 unit per ____ grams of carbohydrate	50% LESS / **USUAL MEAL** / 50% MORE
☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner	1 unit per ____ grams of carbohydrate	50% LESS / **USUAL MEAL** / 50% MORE
☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner	1 unit per ____ grams of carbohydrate	50% LESS / **USUAL MEAL** / 50% MORE
☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner	1 unit per ____ grams of carbohydrate	50% LESS / **USUAL MEAL** / 50% MORE
☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner	1 unit per ____ grams of carbohydrate	50% LESS / **USUAL MEAL** / 50% MORE

Check for KETONES before administering insulin if glucose > ____ mg/dL (default ≥ 250 mg/dL insulin pump or ≥ 300 mg/dL MDI) for > ____ min (default 90) following a meal and/or bolus) or > 400 mg/dL at any time and/or if student complains of physical symptoms (abdominal pain, nausea, vomiting). Refer to section 10 for high blood glucose management guidance.

☐ **School nurse is authorized to adjust** insulin dose to maintain blood glucose in normal ranges during physical actvity.

Insulin dose subtract ____ units from total dose
Insulin dose subtract ____ % from total dose
Carbohydrate grams subtract ____ grams from total
Carbohydrate grams subtract ____ % from total

☐ **Parents/guardians are authorized to adjust insulin dose:**
Insulin dose +/- ____ units
Insulin dose +/- ____ %
Carb ratio +/- ____ grams/units
Correction factor +/- ____ mg/dL/unit

Correction Dose (Table B) May correct every ____ hours (default three hours)

Note: iLet pump corrections are fully automated, no manual corrections are possible via the pump.

Meal or Start/End Time (HR:MIN) ☐ N/A	Correction Formula (Actual Glucose − Target Glucose) / Correction Factor = Correction Dose ☐ N/A	Sliding Scale Correction Dose ☐ N/A
☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner	**Target Glucose:** ____ mg/dL **Correction Factor:** ____ mg/dL/unit	____ to ____ mg/dL = ____ units | ____ to ____ mg/dL = ____ units ____ to ____ mg/dL = ____ units | ____ to ____ mg/dL = ____ units ____ to ____ mg/dL = ____ units | ____ to ____ mg/dL = ____ units
☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner	**Target Glucose:** ____ mg/dL **Correction Factor:** ____ mg/dL/unit	____ to ____ mg/dL = ____ units | ____ to ____ mg/dL = ____ units ____ to ____ mg/dL = ____ units | ____ to ____ mg/dL = ____ units ____ to ____ mg/dL = ____ units | ____ to ____ mg/dL = ____ units
☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner	**Target Glucose:** ____ mg/dL **Correction Factor:** ____ mg/dL/unit	____ to ____ mg/dL = ____ units | ____ to ____ mg/dL = ____ units ____ to ____ mg/dL = ____ units | ____ to ____ mg/dL = ____ units ____ to ____ mg/dL = ____ units | ____ to ____ mg/dL = ____ units

Healthcare Provider Signature: _____ **Date:**

Name of Healthcare Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

Diabetes Medical Management Plan 202 - 202

STUDENT LAST NAME: FIRST NAME: DOB:

9. LOW BLOOD GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Symptoms of Low Blood Glucose May Include: none, hungry, shaky, pale, sweaty, tired/sleepy, tearful/crying, irritable and other mood changes, dizzy, unable to concentrate, poor attention and cognitive function, feelings of panic with or without uncontrolled hunger, confusion.
Symptoms of severe low blood glucose include: low glucose level with inability to follow instructions, eat, or drink carbohydrates, unconsciousness, seizures.

Low Blood Glucose Treatment

☐ **USE DEFAULTS in this section.**

Treatment threshold: < mg/dL or < mg/dL for physical activity (default 70 mg/dL or 120 mg/dL for physical activity).

Treatment amount: One treatment = grams of carbohydrate (default 15 grams if > 80 lbs or 8 grams if < 80 lbs or on active AID System)

Repeat treatment every 15 minutes until BG > mg/dL. (Fingersticks should be performed to confirm if repeat treatment is necessary if using CGM data).

☐ Adjust number of grams used to achieve glucose targets of mg/dL (default 80–120 mg/dL) or mg/dL during physical activity (default 120–180 mg/dL).

☐ **Number of treatments to give based on glucose level and CGM trending (see table below)**

	CGM Trending Arrows by Brand	
	Steady-Slow	Fast-Very Fast
Dexcom App	◯ ◯	◯ ◯
Dexcom Receiver	→ ↘	↓ ↓↓
Libre	→ ↘	↓
Medtronic Guardian and Simplera	None ↓	↓↓ ↓↓↓

	Number of Treatments		
	No CGM	Steady–Slow	Fast–Very Fast
Symptomatic or Impending Low Alarm in normal glucose range	1/2	1/2	1
Mild (Level 1) Hypoglycemia 54 - 69 mg/dL	1	1	2
Serious (Level 2) Hypoglycemia < 54 mg/dL	2	2	2
Severe (Level 3) Hypoglycemia Irrespective of Glucose Level	**Unconsciousness, seizure, unable to drink or swallow, requiring assistance with treatment. Administer severe low glucose treatment outlined below.**		

For example: Dexcom is showing 60 mg/dL ↓↓. This indicates mild (level 1) hypoglycemia with a very fast drop. The table instructs to give 2 treatments. If one treatment = 8 grams, give two or 16 grams to treat for Level 2 hypoyglycemia. Reassess glucose in 15 minutes.

Automated Insulin Delivery (AID) systems: Insulin suspends automatically to avoid hypoglycemia, reducing amount of treatment required. Overtreatment of lows, above Target Glucose (150 mg/dL if using exercise/activity features) leads to extra insulin delivery and can cause rebound hypoglycemia.

Mild (Level 1) and Serious (Level 2) Carbohydrate Guidelines (Low Glucose, Conscious, and Able to Swallow)
Use only fast-acting carbohydrates such as juice, fat-free milk, glucose tablets/gels/gummies, honey, jam/jelly, sugar candies (jelly beans, Life Savers, Smarties, etc.), regular soda. Avoid fats, protein, fiber-rich foods when treating low glucose readings.

Severe (Level 3) Low Glucose Treatment Glucagon Guidelines
1. Administer glucagon. 2. Position student on their side and monitor for vomiting 3. Call 911 and notify parent/guardian. If BG meter is available, confirm hypoglycemia via BG fingerstick. Do not delay treatment if meter is not immediately available. If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with student.

☐ Gvoke PFS (prefilled syringe) or HypoPen (auto-injector) SC Injection ☐ 0.5 mg ☐ 1.0 mg
☐ Gvoke Kit (ready-to-use vial and syringe, 1mg/0.2 ml) SC injection
☐ Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe
☐ Baqsimi Nasal Glucagon 3 mg
☐ Glucagon Emergency Kit IM ☐ 0.5 mg ☐ 1.0 mg
☐ Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector

Exercise Features for Pumps/AID Systems: ☐ **USE DEFAULTS in this section.**

☐ Initiate feature minutes prior to start of physical activity (Default 60-90 minutes) as needed to prevent hypoglycemia and maintain glucose levels in safe range (Default 120–180 mg/dL).
(Medtronic) 770/780G/FLEX Temp Target or Preset Temp Basal, (Insulet) Omnipod 5 or DASH Activity Feature or Preset Temp Basal, (Tandem) CIQ or Mobi Exercise Activity Setting or Temp Rate, (Beta Bionics) iLet Suspend, (Twiist) Workout Presets.

☐ May suspend and disconnect from tubed insulin pump for up to minutes (Default 60 minutes) to avoid harm to student and/or device. Store in cool and clean place.

☐ **Extended Exercise** > 30 minutes may require additional snacks to maintain glucose levels in safe ranges mg/dL (default 120–180 mg/dL). Give gram snack (may include protein/fiber once in target range as additional snack for extended exercise).

Encourage water, provide access to carbohydrates, allow glucose monitoring, and approve bathroom privileges during physical activity. Observe student for signs of high and low glucose levels.

Name of Healthcare Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

10. HIGH BLOOD GLUCOSE MANAGEMENT (HYPERGLYCEMIA)

Symptoms of High Blood Glucose May Include: ☐ **USE DEFAULTS in this section.**
None, thirsty, frequent urination, fatigued/tired, drowsy, headache, blurred vision, warm/dry/flushed skin, anger, mood swings, inability to concentrate or recall information.

Symptoms associated with ketones include: abdominal discomfort, nausea, vomiting, fruity breath. **Symptoms of DKA include deep rapid breathing, coma, and seizures.**

Management of high glucose over mg/dL (default is 300 mg/dL MDI OR 250 mg/dl if on an insulin pump) for minutes (default 90 minutes following last insulin bolus/meal), >400 mg/dL at any time or with physical complaints of not feeling well regardless of glucose level.

1. Provide and encourage consumption of water or sugar-free fluids. Give 4–8 ounces of water every 30 minutes.
2. Check for ketones (before giving insulin correction)
   a. If **trace or small** urine ketones (blood ketones: 0.1–0.5 mmol/L)
      - Consider insulin correction dose and refer to the Dosing Table in section 8. for designated times correction insulin may be given. (Correction dosing via the iLet pump is fully automated and an additional correction dose is not possible).
      - *Can return to class and PE unless symptomatic. Avoid intense exercise if glucose level is >350 mg/dL.*
      - Recheck blood glucose and ketones in two hours

   b. If **Moderate or large** urine ketones (blood ketones 0.6–1.5 mmol/L or >1.5 mmol/L, respectively). This may be serious and requires action.
      - **Contact parents/guardian or, if unavailable, healthcare provider**
      - **Administer correction dose via injection for all students.**
      - Call 911 if changes in mental status and labored breathing are present.

      For insulin pump users: Change infusion site/cartridge or use injections until dismissal.
      - If injecting while using an AID system, turn off automation for three to four hours following injections. For iLet users **discontinue insulin pump** for 90 minutes following injection.
      - No physical activity until ketones are less than moderate.

Send student's diabetes logs to healthcare provider (include details): If pre-meal blood glucose is below 70 mg/dL or above 250 mg/dL more than three times per week or if you have any other concerns about the medical orders.

Student's healthcare provider SIGNATURE (physician, physician assistant, or advanced practice registered nurse):

Physician/Healthcare Provider Signature: Date: Healthcare Provider Printed Name:

Parent/Legal Guardian Acknowledgment:

I, as parent/guardian, give permission to the school nurse or another qualified healthcare professional or trained diabetes personnel to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have 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 school nurse or another qualified healthcare professional to collaborate with my child's physician/healthcare provider.

Student's Parent/Guardian Signature: Date: Parent/Legal Guardian Printed Name:

School Nurse or Designee Acknowledgment:

School Nurse or Designed Signature: Date: School Nurse or Designee Printed Name:

Name of Healthcare Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other: