University of Illinois College of Medicine at Peoria

OSF HealthCare Children's Hospital of Illinois

# Diabetes Medical Management Plan (DMMP)

**Student:**_____ DOB: _____ Date: _____
School:_____ School year: _____ to _____
School Fax #: _____ School Phone #: _____

## Diabetes Health Care Provider

□ Valeria Benavides, MD □ Mark Miller, MD □ Michael Torchinsky, MD
□ Sarah Dominique, APRN □ Samantha Robbins APRN □ Anu Vishwanath, MD □ _____

**Address:** **Pediatric Diabetes Resource Center** (**PDRC**), 530 NE Glen Oak, Peoria, IL 61637
**Office Phone:** 309-624-2480 OR 1-888-436-2278 *[if Urgent, Press 2 to speak to nurse]*
**Fax:** 309-624-2481 **Email:** diabetescenter@osfhealthcare.org

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## Monitor Blood Glucose: □ Before breakfast if eating breakfast at school □ Before lunch

□ As needed for symptoms of low or high blood glucose or illness □_____

Target range for blood glucose: _____ to _____ mg/dL

**Methods of Monitoring:**

**Finger Stick:** ● Use fingertip with lancing device and blood glucose meter.
● For students not wearing a sensor

**Sensor (sometimes called CGM):** Sensor: _____
● Finger stick monitoring is necessary if student's symptoms do not match sensor reading and/or sensor reading is missing an arrow and/or number.

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## Hypoglycemia *Blood glucose reading less than 70 mg/dL; also known as Low Blood Sugar*

***Do not leave student alone if low blood sugar is suspected or confirmed.***

***Mild*** symptoms: Student is alert and shows signs of shakiness, dizziness, sweating, extreme hunger, fatigue, weakness, pale skin color, behavioral changes, other: _____

Treatment: ● Give 15 grams rapid-acting carbohydrate (e.g. glucose tabs, juice) with NO insulin.
● Recheck blood glucose in 15 minutes after treating. Repeat treatment if blood glucose is less than 70 mg/dL and/or symptoms persist. Continue until over 70 mg/dl.

□ Student has an automated loop system (Control-IQ or Omnipod 5). If system is in use, may treat mild low blood sugars with **less than 15 grams** carbohydrate as system also treating. 504 plan to specify amount

***Moderate*** *symptoms*: Student shows signs of confusion, headache, unwilling to swallow due to nausea/vomiting, combativeness

Treatment: ● Keeping head elevated, give 15 grams carbohydrate using glucose/icing gel applied between cheek and gum.
● Recheck blood glucose in 15 minutes after treating. Repeat treatment if blood glucose is less than 70 mg/dL and/or symptoms of hypoglycemia persists.

***Severe*** symptoms: seizures, unconsciousness, unable/unwilling to swallow or keep gel in mouth

Treatment: □ Inject Glucagon or GlucaGen®: 0.5 mg 1.0 mg intramuscularly (IM) in outer thighs or buttock. Can inject through clothes.

□ Administer Baqsimi™: Place tip of device into one nostril until fingers touch the outside of the nose; press device plunger all the way in until green line gone.

• ***Do not remove the Shrink Wrap or open the tube until time of use.***

□ Inject Gvoke™ or Zegalogue™: 0.5 mg 0.6 mg 1.0 mg subcutaneously in stomach, thigh or upper arm; hold for 10 seconds and ensure window turns red

• ***Do not open foil pouch or remove cap until time of use*.**

- If student's prescribed severe hypoglycemia medication is not available on-site or has expired, undesignated glucagon may be used **if available**.
- Contact parent/guardian, school nurse, and healthcare provider to report use of medication.
- Call 9-1-1 if specified in 504 Health Plan or student does not respond within 15 minutes.
- After using, turn student on side. Vomiting may occur.
- Do not refrigerate or freeze severe low blood glucose medications- keep at room temperature.

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**Hyperglycemia** *Any blood glucose reading above target blood glucose. Also called high blood sugar.*

***Ensure student has frequent bathroom privileges and water access.***

Treatment: • Give student water to drink. Give correction insulin dose before meals.

• Check for urine ketones if student has <u>one</u> or <u>more</u> of the following:

- nausea - vomiting - headache - "feels sick" - stomach pain - fever

***- unexpected*** blood glucose above ***300*** mg/dL for ***two*** routine checks in a row or over 3 hours

*When* ***<u>trace or small</u>*** urine ketones are present:

- Push sugar free fluids: 8 ounces of water every 30 – 60 minutes.
- Check blood glucose and urine ketones every two hours
- Give correction insulin dose using rapid-acting insulin every two hours.

*When* ***<u>moderate to large</u>*** ketones are present:

- Continue to push sugar free fluids: 8 ounces of water every 30-60 minutes.
- First calculate correction insulin dose for current blood glucose. Next, calculate the ketone treatment insulin dose using the following:

  *For* ***<u>moderate</u>*** *urine ketones:* Multiply correction insulin dose by **1.5**

  *For* ***<u>large</u>*** *urine ketones:* Multiply correction insulin dose by **2.0**
- Administer insulin by syringe or insulin pen ***even if student is on an insulin pump***.
- If on insulin pump therapy, change the infusion site if supplies available
- Avoid physical activity **only if** ketones are moderate or large until ketones have cleared.
- Recheck blood glucose and urine ketones ***<u>every two hours</u>***. Repeat treatment until ketones are small, trace, or none.
- ***Call 9-1-1 if student has any of the following symptoms: chest pain, shortness of breath, heavy breathing, and/or decreased level of consciousness.***

***Special Consideration: ketones without hyperglycemia***

- If student has ketones, but blood sugar not above 120 mg/dL, treat with 15 grams of carbohydrates every 15 minutes until the blood glucose is greater than 120 mg/dL. Once blood glucose over 120 mg/dL, give insulin correction dose with ketone multiplier as detailed above.

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**Diet** □ Count carbohydrates in foods/drink. Total grams of carbohydrate student eats can vary.

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## Medication

- PDRC recommends administering insulin ***before*** the student eats. Timing of insulin should be clarified with parent/guardian at 504 Health Plan meeting.
- Do **not** correct a blood glucose checked less than ***two hours*** after insulin administration.

Rapid-acting insulin: _____ Given by: □ syringe or insulin pen
□ half unit □ whole unit

□ insulin pump: _____

**Dose information for rapid-acting insulin:**

***Blood Glucose Correction:***

Blood glucose target: _____ mg/dL Correction/sensitivity factor: 1 unit/_____

***Carbohydrate counting:*** Give 1 unit rapid-acting insulin per specified grams of carbohydrate

Insulin-to-carbohydrate ratio:

Breakfast: 1 unit: _____ grams

Lunch: 1 unit: _____ grams

**How to calculate rapid-acting insulin doses at meal times:**

***Correction insulin dose:***

High blood glucose reading **–** Blood glucose target **=** _____ **÷** Correction /Sensitivity factor **=** Correction insulin dose

***Food insulin dose:***

Total grams carbohydrate in meal **÷** Insulin-to-carbohydrate ratio **=** Food Insulin dose

***Total insulin dose:***

Correction insulin dose **+** Food insulin dose **=** Total insulin. Round total insulin only.

*An insulin pump will calculate the insulin dose when blood glucose and/or total grams of carbohydrates are entered into pump. Allow the pump Bolus Calculator to determine dosing unless special circumstances.*

## Snacks

Routine snacks are not required; however, student is allowed to have snacks the same as classmates. Blood glucose monitoring is not required with snacks. Insulin is to be given for carbohydrates unless specified differently in 504 Health Plan. (For students using injection therapy, a low carb snack may not need insulin.) **Clarify plan with parent/guardian.**

## Student's Self-Management

Per Illinois law, student should have access to supervision, support and assistance by properly trained school personnel. Details of support should be discussed with student and parent/guardian at 504 Health Plan meeting. PDRC recommendations for this student are:

□ Student requires adult full support with diabetes tasks.
□ Student can perform diabetes tasks but requires adult supervision that tasks are completed correctly.
□ Student independently self-manages diabetes, requiring assistance only for emergency care.

Please ensure student absences from class are minimized. Diabetes care, dealing with high or low blood sugars and ketones, can all be done in the classroom or student returned to classroom as soon as possible.

**Dose Adjustments** Parent/guardian is authorized to change doses as needed. New Diabetes Medical Management Plan is not needed for dose adjustments.

□ Yes □ No □ Parent should check dose changes with PDRC staff and can convey to school

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## Diabetes Supplies

**PDRC teaches that all diabetes supplies should be in the same room as the student at all times, in accordance with school law, and with awareness of unexpected situations including lockdown, tornado, and fire. In 504 plan, can specify if student will carry supplies or if adults should facilitate ensuring supplies follow student around school.**

The following diabetes supplies and equipment are used to monitor and treat diabetes:

| | | | |
|---|---|---|---|
| glucometers | lancets/lancing device | blood glucose test strips | insulin |
| batteries/charger | ketone test strips | food/drink/snacks | |
| syringes/pen needles | rapid-acting carbohydrates | pump supplies (including infusion sets/pods) | |
| sensor | receiver/reader/smartphone | severe hypoglycemia medication(s) | |

*Handling of <u>used</u> sharps should be in accordance to FDA guidelines.*

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## Other _____

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_____

_____

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## Signatures

My signature below provides authorization for the above written orders and exchange of health information to assist the trained diabetes care aid/school nurse/school administrator in developing an individualized 504 Health Plan.

Physician/Health Care Provider: _____ Date: _____

I give permission for my child's healthcare provider to share information with the school for completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school whenever there is any change in the student's health status or care. School may contact parent/guardian if questions regarding diabetes care arise. I also give the school permission to contact my child's health care provider.

Parent/Guardian: _____ Date: _____

As parent/guardian of the above named student, I give my permission to the diabetes care aide/school nurse/school administrator or other trained designated staff to perform and carry out the diabetes tasks as outlined in this Diabetes Medical Management Plan and/or 504 Medical Plan.

Parent/Guardian: _____ Date: _____

School Representative: _____ Date: _____