Conductor Name	Pa	
	D.O.B.:	
School:		
FATHER/GUARDIAN NAME:	MOTHER/GUARDIAN NAME:	
ADDRESS:	ADDRESS:	
EMAIL:		
CELL PHONE:		
FATHER'S EMPLOYER:	MOTHER'S EMPLOYER:	
WORK PHONE:	WORK PHONE:	
	RGENCY WHEN PARENT/GUARDIAN CANNOT BE REACHED ENCY CONTACTS	
NAME:	T	
PHONE:	PHONE:	
EMAIL:	EMAIL:	
RELATIONSHIP:	RELATIONSHIP:	
Name:	Title:	
Name:		
Parent/Guardian Signature:	Date:	
e completed by the School:		
This Diabetes Medical Management Plan has bee	en reviewed by:	
school Nurse/Health Coordinator Signature:	Date:	
Principal Signature:	Date:	
Before & After Program Coordinator Signature:	Date:	
Γeacher notification provided by:		
School Personnel Signature	Date:	

e completed by the P	hysician:			Pa
Date of Plan:				
			Date of Birth:	
Date of Diabetes Dia	gnosis:	type 1	Other	
School:		School Phone:		
Grade:	Teacher:	Nurse:		
Physician:		Office Phone:		
Address:				
CHECKING BLO	OD GLUCOSE			
Brand/Model of bloo	od glucose meter:			
Target range of bloc	od glucose: 70-1	30 mg/dL	Other:	
Check blood glucose	e level:			
☐ Before breakfast	After breakfast	Hours after breakfast	2 hours after a correction dose	
☐ Before lunch	After lunch	Hours after lunch	Before dismissal	
☐ Mid-morning	☐ Before PE	After PE	Other:	
As needed for sign	s/symptoms of low or h	nigh blood glucose As needd	ed for signs/symptoms of illness	
Preferred site of test	ing: Fingertip	Forearm Thigh Other:		
Note: The, fingertip si	hould always be used t	to check blood glucose level if hypo	glycemia is suspected.	
Student's self-care	blood glucose check	king skills:		
☐ Independently cl	necks own blood glu	cose		
May check blood	d glucose with super	vision		
Requires school	nurse or trained diabo	etes personnel to check blood glu	icose	
Uses a smartpho	ne or other monitorin	g technology to track blood gluc	ose values	
Continuous Glucose	Monitor (CGM):	Yes No Brand/Model:		
Alarms set for: S	evere Low:	Low: High:		
Predictive alarm: I	H	ligh: Rate of chang	ge: Low: High:	
Threshold suspend s	etting:			

To be completed by the Physician:

Page 3

Additional information for student with CGM

- Confirm CFG results with a blood glucose meter check before taking action on the sensor blood glucose level. If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- 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 any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's S	Independent?		
The student troubleshoots alarms	and malfunctions.	□ YES	□ NO
The student knows what to do an	d is able to deal with a HIGH alarm.	□ YES	□NO
The student knows what to do an	d is able to deal with a LOW alarm.	□ YES	□ NO
The student can calibrate the CG	M.	□ YES	□ NO
The student knows what to do wherise or fall in the blood glucose le	□ YES	□NO	
	nurse if the CGM alarm goes off:	□ №	
f exhibiting symptoms of hypoglycemia	OR if blood glucose level is less thangrams of carbohydrate.	mg/dL, giv	ve a quick-acting
Recheck blood glucose in 10-15 minutes	and repeat treatment if blood glucose level is	less than	mg/dL.
Additional treatment:			
f the student is unable to eat or drink, i	s unconscious or unresponsive, or is having	g seizure activity of	or convulsions:
• Position the student on his or h	er side to prevent choking.		
• Give glucagon:	☐ 1 mg ☐ 1/2 mg ☐ Other	:	
• Route:	☐ Subcutaneous (SC) ☐ Intran	nuscular (IM)	
 Site for glucagon inject 	tion: Buttocks Arm Thigh	Other:	
• Call 911 (Emergency Medica	l Services) and the student's parents/guardi	an.	
 Contact student's health care 	provider.		

Updated January 2023

Archdiocese of Galveston-Houston | Catholic Schools Office, 2023-2024

To be completed by the Physician: Page 4 HYPERGLYCEMIA TREATMENT Student's usual symptoms of hyperglycemia (list below): **CHECK:** Urine Blood for ketones every hours when blood glucose levels are above mg/dL. For blood glucose greater than _____mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders). Notify parents/guardians if blood glucose is over mg/dL. For insulin pump users: see Additional information for Students with Insulin Pump. Allow unrestricted access to the bathroom. Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ounces per hour. Additional treatment for ketones: Follow physical activity and sports orders. (See Physical Activity and Sports) If the student has symptoms of a hyperglycemia emergency, Call 911 (Emergency Medical Services) and contact the student's parents/guardians and healthcare provider. Symptoms of hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness. **INSULIN THERAPY** Syringe Insulin pen Insulin pump **Insulin delivery device**: **Type of insulin therapy at school:** Adjustable (basal-bolus) Insulin Fixed Insulin Therapy No insulin ADJUSTABLE (Basal-bolus) INSULIN THERAPY • Carbohydrate Coverage/Correction Dose: Name of insulin: • Carbohydrate Coverage: Insulin-to-Carbohydrate Ratio: *Breakfast*: 1 unit of insulin per _____grams of carbohydrate **Lunch**: 1 unit of insulin per ______grams of carbohydrate **Snack**: 1 unit of insulin per ______grams of carbohydrate Carbohydrate Dose Calculation Example

Correction Dose: Blood glucose correction factor (insulin sensitivity factor) = _____ Target blood glucose = _____mg/dL

Correction Factor

<u>Total Grams of Carbohydrates to Be Eaten</u> = _____ Units of Insulin

To be completed by the Physician:

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INSULIN THERAPY (continued)

	Correction Dose Calcula	tion Example	
	cose- Target Blood Gluco rrection Factor	<u>se</u> = Units of I	Insulin
Correction Dose Scale (use instead	d of calculation above to de	etermine insulin correction do	se):
Blood glucose	to mg/dL	, give units	
Blood glucose	to mg/dL	, give units	
Blood glucose	to mg/dL	, give units	
Blood glucose	to mg/dL	, give units	
☐ Other:	orrection dose when blood hours since last insulin dose	glucose is greater than	
Carbohydrate coverage plus c mg/dL and Correction dose only: For blo last insulin dose. Other:	hours since last insulin do	se mg/dL AND at leas	
Fixed Insulin Therapy			
Name of insulin: Units of insulin giver Units of insulin giver Units of insulin giver Other:	n pre-breakfast daily n pre-lunch daily n pre-snack daily		

To be completed by the Physician:

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INSULIN THERAPY (continued)

Parental A	uthoriza	ation to Adjust Insulin Dose:				
□ YES	□ NO	Parents/guardians authorization should be obtained before administering a correction dose.				
□ YES	□ NO	rents/guardian are authorized to increase or decrease correction dose scale within following range: +/units of insulin.				
□ YES	□NO	rents/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio thin the following range:units per prescribed grams of carbohydrate, +/grams of carbohydrate.				
□ YES	□NO	arents/guardian are authorized to increase or decrease fixed insulin dose within the bllowing range: +/ units of insulin.				
Student's s	elf-care	insulin administration skill				
Yes	N	Independently calculates and gives own injections				
Yes	N	May calculate/give own injections with supervision				
Yes	N	Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision				
Yes	N					
		DRMATION FOR STUDENT WITH INSULIN PUMP D: Type of insulin in pump:				
		ool: Time: Basal rate: Time: Basal rate:				
Dasai fales du	ning sen	Time: Basal rate: Time: Basal rate:				
		Time: Basal rate:				
Other pump in	struction	is:				
Type of infusio	on set:	<u> </u>				
Appropriate in	fusion si	te(s):				
For blood g	glucose g	greater thanmg/dL that has not decreased within hours after correction,				
consider p	ump failı	ure or infusion site failure. Notify parents/guardians.				
For infusion	n site fai	lure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.				
For suspect	ed pump	failure: Suspend or remove pump and give insulin by syringe or pen.				

Physical Activity					
May disconnect from pump for sp	orts activities: Y	es, for	hours		☐ No
Set a temporary basal rate	☐ Y	es,% to	emporary bas	al for	hours No
Suspend pump use:	Y	es, for	hours		☐ No
Student's S	elf-Care Pump Ski	lls		Inde	pendent?
Counts carbohydrates	-			□ YES	□NO
Calculates correct amount of insul	in for carbohydrates	consumed		□ YES	□NO
Administers correction bolus				□ YES	□NO
Calculates and sets basal profiles				□ YES	□NO
Calculates and sets temporary base	al rate			□ YES	□NO
Changes batteries				□ YES	□NO
Disconnects pump				□ YES	□NO
Reconnects pump to infusion set				□ YES	□NO
Prepares reservoir, pod and/or tub	ing			□ YES	□NO
Inserts infusion set				□ YES	□NO
Troubleshoots alarms and malfund	etions			□ YES	□NO
	AFTONG				
OTHER DIABETES MEDIC. Type of Medication	ATIONS	Name of Medica	tion and Strength		
Prescription Non-Pre	escription Date to End Medication		Time to be Given	2	Amount to be Given
Sate to begin inedication	Date to End Medication		Time to be given		Amount to be given
Form of Medication					Route (ex: or
☐ Tablet ☐ Capsule ☐ Liq	uid	Injection	Other _		
Type of Medication Prescription Non-Pre		Name of Medica	tion and Strength		
I Proggription I Non Pro	escription				

To be completed by the Physician:

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M	$\mathbf{F}_{\cdot}\mathbf{A}$	I.	PI	. 4	N

Meal/Snack	Time	Carboh	ydrate Content (gran	ns)
Breakfast			to	
Mid-morning snack			to	
Lunch		to		
Mid-afternoon snack			to	
Other times to give snacks and	content/amount:			
Instructions for when food is pr	rovided to the class (e.g., as	part of a class party or fo	ood sampling event):	
Special event/party food permit	ted: Parents/guardian o	discretion Student	t discretion	
Student's	Self-Care Nutritional Skil	lls		
Independently counts carbohyo		\Box YES	□NO	
May count carbohydrates with		\Box YES	□ NO	
Requires school nurse/trained diabetes personnel to count carbohydrates				□NO
A quick-acting source of glucose: Source of glucose: Student should eat: Times to consume:	Glucose tabs and/or 15 grams 30 gra	Sugar-containing ms of carbohydrate	juice other:	
Times to consume: Before activity Every 30min during activity Every 60 min during activity After physical activity Other:				
If most recent blood glucose blood glucose is corrected an	nd abovemg/dl	L.		
Avoid physical activity when are moderate to large.	-		_	od ketones
(Additional information for s	tudent on insulin pump is	in the insulin section.	.)	

To be completed by the Physician and Parent/Guardian:

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DISASTER PLAN	
To prepare for an unplanned disaster or emergency (72 hours), parents/guardians.	obtain emergency supply kit from
Continue to follow orders contained in this DMMP.	
Additional insulin orders as follow (e.g., dinner and nightti	me):
Other:	
SIGNATURES	
This Diabetes Medical Management Plan has been approved by:	:
Student's Physician/Health Care Provider	Date
Acknowledged and received by:	
Student's Parent/Guardian	Date

SELF-CARRY AND SELF-ADMINISTER DIABETES MEDICATION AGREEMENT 2023-2024 SCHOOL YEAR

pe completed by the Parent and Student:
ent name: Date of Birth:
re will student carry diabetes medication (required):
itional diabetes medication will be provided to the school and stored with prescribed medication at specified
ol location: (required):
STUDENT
I will notify school personnel if I am having more difficulty than usual with my diabetes.
I agree to carry my diabetes medication/supplies with me as listed above. If an emergency arises and I am unable to get to the nurse/school personnel, I will use the diabetes medication as prescribed by the physician and then immediately inform a nurse/school personnel.
I agree to use my diabetes medication/supplies in a responsible manner, in accordance with the physician's orders. I understand my diabetes signs, symptoms, and treatment plan reviewed by my physician and parent(s)/guardian(s) and understand to use my diabetes medication/supplies as prescribed by my physician.
I agree to never share my diabetes medication/supplies with another person as this is dangerous. If I do this may result in disciplinary action.
udent Signature: Date:
PARENT/GUARDIAN
I agree to see that my child carries his/her diabetes medication/supplies as prescribed, and that it is properly labeled and is not expired.
I understand that I will provide the school with an additional diabetes medication/supplies to store at school along with any prescribed medication(s) from the physician treatment plan.
I have reviewed with my child his/her diabetes signs, symptoms and treatment plan including the usage of the self-carry diabetes medication/supplies.
I agree to regularly review with my child the proper use of his/her diabetes medication/supplies when at school.
I agree to regularly review the status of my child's diabetes with the physician and to notify the physician when my child is having more difficulty than usual.
I understand if my child shares medication/supplies with other students it may result in disciplinary actions.
My child has demonstrated to his/her physician and the school, nurse, if available, the skill level necessary to self-administer the prescription medication, including the use of any device required to administer the medication in case an emergency arises and they are unable to get to a school personnel/nurse.
The self-administration is done in compliance with the prescription or written authorization for my child to self-administer the medicine while on school property or at a school-related event or activity.

Parent Signature: ______ Date: _____