Perry Township Schools
Diabetes Medical Management Plan

NAME: **Student Name**   **DOB:**   Student Birthdate   **SCHOOL:**   **School Name**

PARENTS: **Guardian(s) Primary**

ADDRESS: Guardian(s) Primary Address Box

PHONE: **Guardian(s) Primary Phone**

1. PHYSICIAN(S) / HEALTHCARE PROVIDER(S) - List specialty, phone number, fax number, email address:

2. OTHER EMERGENCY CONTACT(S) - List name, relationship, phone number:

3. DIAGNOSIS - List <u>date</u> of onset and <u>type</u> of diabetes:

4. ALLERGIES:

5. INSULIN THERAPY (OR ORAL MED) - If <u>not</u> listed in orders, list type of therapy, administration time/frequency, carb coverage ratio or ordered dose, preferred injection site, level of independence (requires supervision, self-care, trained personnel must perform care):

6. BLOOD SUGAR CHECKS- If <u>not</u> listed in orders, list times, target range, level of independence (requires supervision, self-care, trained personnel must perform):

7. HYPOGLYCEMIA and HYPERGLYCEMIA TREATMENT - List symptoms of highs and lows for this student. If not included in orders, summarize physical activity orders, fast-acting glucose orders, emergency care (glucagon dose and preferred injection site), when to check ketones and intervention guidelines for high blood sugar):

8. UNLICENSED PERONNEL TRAINING - List name, title, type and date of training. Also, list bus number and/or driver (if bus rider):

9. EQUIPMENT/SUPPLIES TO BE KEPT AT SCHOOL (Provided by parent/guardian):

DMMP written by: _____   Clinic assistant name: _____ – Date: <u>Todays Date</u>

Nurse's signature and title

Cc: School/Caregiver and Parent/Guardian

X

SIGNATURE OF PARENT OR GUARDIAN
Addendum: Pertinent MD orders, unlicensed personnel training forms and two-way release included in student's Skyward health records as needed.