Diabetes Medication Management Orders (DMMO)

In Accordance with UCA 53G-9-504 and 53G-9-506
Utah Department of Health/Utah State Board of Education

HEALTHCARE PROVIDER:
Name:
Phone:
Fax:

STUDENT INFORMATION School Year:

Student Name: ☐ Type 1 ☐ Type 2		School:
DOB:	Age at diagnosis:	School Fax:
Parent Name:	Phone:	Phone:
Emergency Contact:	Relationship:	Phone:

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER

EMERGENCY GLUCAGON ADMINISTRATION

Immediately for severe hypoglycemia: unconscious, semiconscious (unable to control airway, or seizing)	Glucagon Dose: ☐ IM 1.0 mg/1.0 ml ☐ Nasal (Baqsimi) 3 mg ☐ SQ (Gvoke) 0.5 mg ☐ SQ (Gvoke) 1.0 mg	Possible side effects: Nausea and Vomiting

BLOOD GLUCOSE TESTING

Target range for blood glucose (BG): ☐70-150 ☐80-150 ☐100-200 ☐ Other:

Times to test: ☐ Before meals ☐ If symptomatic ☐ Other:

☐ If symptomatic (See student's specific symptoms in Individualized Healthcare Plan (IHP).

- If BG is less than ____ mg/dl, follow management per Diabetes Emergency Action Plan (EAP).
- Student should not exercise if BG is below ____ mg/dl or symptomatic of hyperglycemia.

CONTINUOUS GLUCOSE MONITORING (CGM): <u>If student has a CGM, the CGM Addendum is required.</u>
All students using a CGM at school must have the ability to check a finger stick blood glucose with a meter in the event of a CGM failure or apparent discrepancy. Student is currently using the following CGM:

☐ Dexcom G4 ☐ Dexcom G5 ☐ Dexcom G6 ☐ Freestyle Libre
☐ Medtronic 530G ☐ Medtronic 630G ☐ Medtronic 670 G ☐ Guardian Connect
☐ None ☐ Other:

CARBOHYDRATE COUNTING

☐ Student is capable to independently count carbohydrates at meals and snacks for insulin administration.
☐ Student requires a trained adult to supervise carbohydrate counting of meals and snacks for insulin administration.
☐ Student requires a trained adult to carbohydrate count meals and snacks <u>and</u> administer insulin.

INSULIN ADMINISTRATION

☐ Humalog ☐ Novolog ☐ Apidra ☐ Admelog ☐ Lispro ☐ Aspart ☐ Fiasp ☐ Other:	☐ Insulin vial/syringe ☐ Insulin pen ☐ Insulin pump	Route: Subcutaneous	Possible side effects: Hypoglycemia

INSULIN TO CARBOHYDRATE (I:C) Ratio: ____ unit for every ___ grams of carbohydrates before meals.

CORRECTION DOSE (meals only): ____ unit for every ____ mg/dl for blood glucose above ___mg/dl.

SNACKS/PARTIES:
☐ Snacks/parties (use I:C ratio) ☐ No coverage for snacks/parties ☐ Contact parent/guardian

INSULIN PUMP: If using insulin pump, carbohydrate ratio and correction dose are calculated by pump. Correction doses at times other than meals per PUMP calculation ONLY.
ADDITIONAL PUMP ORDERS: Student may be disconnected from pump for a maximum of 60 minutes, or per IHP/EAP. If unable to use pump after 60 minutes contact parent/guardian. If able to reconnect pump, administer correction dose with (syringe or insulin pen) as calculated by pump.

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Student Name:	DOB:	School Year:

ADDITIONAL ORDERS:

☐ None

☐Please allow free and liberal access to water and the restroom.

☐Please allow student to keep their cell phone with them at all times if it is being used as a medical device to receive and transmit data from their CGM.

☐Please allow student to leave class 10 minutes prior to lunch to manage their diabetes.

☐ Other:

PRESCIBER SIGNATURE

The above named student is under my care. This document reflects my plan of care for the above named student. In accordance with these orders, an Individualized Healthcare Plan (IHP), an Emergency Action Plan (EAP), (and if appropriate) the CGM Addendum must be developed by the school nurse, student, and parent to be shared with appropriate school personnel. As the student's licensed healthcare provider:

☐ I confirm the student has a diagnosis of diabetes mellitus.

☐ It IS medically appropriate for the student to possess and self-administer diabetes medication. The student should be in possession of diabetes medications at all times.

☐ It is NOT medically appropriate for the student to possess, or self-administer diabetes medication. The student should have access to their diabetes medications at all times.

☐ This student may participate in ALL school activities, including sports and field trips, with the following restrictions:

Prescriber Name (print):	Phone:
Prescriber Signature:	Date:

PARENT SIGNATURE

I understand that a school team, including a parent or guardian, may make decisions about implementation and assistance in the school based on consideration of the above recommendations, available resources, and the student's level of self-management. I acknowledge that these orders signed by the LIP will be used by the school nurse, and shared with appropriate school staff, to develop the IHP for my student's diabetes management at school. I understand and accept the risk that in the course of communication between myself, the school, and the provider, protected health information (PHI) sent via unencrypted email or text message may be intercepted and read by third parties.

Parent Name:	Signature:	Date:

SCHOOL NURSE *(or principal designee if no school nurse)*

☐ Signed by licensed healthcare provider and parent	☐ Medication is appropriately labeled	☐ Medication log generated

Glucagon is kept: ☐NA ☐Student Carries ☐Backpack ☐In Classroom ☐Health Office ☐Front Office ☐Other:

Diabetes Emergency Action Plan distributed to 'need to know' staff:

☐ Teacher(s) ☐ PE teacher(s) ☐ Transportation ☐ Front Office/Admin ☐ Other (specify):

School Nurse Signature:	Date: