

Diabetes Medication Management Order (DMMO)

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:	<input type="checkbox"/> Type 1 <input type="checkbox"/> 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: <input type="checkbox"/> IM 1.0 mg/1.0 ml <input type="checkbox"/> Nasal (Baqsimi) 3 mg <input type="checkbox"/> SQ (Gvoke) 0.5 mg <input type="checkbox"/> SQ (Gvoke) 1.0 mg	Possible side effects: Nausea and Vomiting	
BLOOD GLUCOSE TESTING			
Target range for blood glucose (BG): <input type="checkbox"/> 70-150 <input type="checkbox"/> 80-150 <input type="checkbox"/> 100-200 <input type="checkbox"/> Other:			
Times to test: <input type="checkbox"/> Before meals <input type="checkbox"/> If symptomatic <input type="checkbox"/> Other: <input type="checkbox"/> If symptomatic (See student's specific symptoms in Individualized Healthcare Plan (IHP). <ul style="list-style-type: none"> • 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): If student has a CGM, the CGM Addendum is required. 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:			
<input type="checkbox"/> Dexcom G4 <input type="checkbox"/> Dexcom G5 <input type="checkbox"/> Dexcom G6 <input type="checkbox"/> Freestyle Libre <input type="checkbox"/> Medtronic 530G <input type="checkbox"/> Medtronic 630G <input type="checkbox"/> Medtronic 670 G <input type="checkbox"/> Guardian Connect <input type="checkbox"/> None <input type="checkbox"/> Other:			
CARBOHYDRATE COUNTING			
<input type="checkbox"/> Student is capable to independently count carbohydrates at meals and snacks for insulin administration. <input type="checkbox"/> Student requires a trained adult to supervise carbohydrate counting of meals and snacks for insulin administration. <input type="checkbox"/> Student requires a trained adult to carbohydrate count meals and snacks and administer insulin.			
INSULIN ADMINISTRATION			
<input type="checkbox"/> Humalog <input type="checkbox"/> Novolog <input type="checkbox"/> Apidra <input type="checkbox"/> Admelog <input type="checkbox"/> Lispro <input type="checkbox"/> Aspart <input type="checkbox"/> Fiasp <input type="checkbox"/> Other:	<input type="checkbox"/> Insulin vial/syringe <input type="checkbox"/> Insulin pen <input type="checkbox"/> 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:			
<input type="checkbox"/> Snacks/parties (use I:C ratio) <input type="checkbox"/> No coverage for snacks/parties <input type="checkbox"/> 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: <input type="checkbox"/> None <input type="checkbox"/> Please allow free and liberal access to water and the restroom. <input type="checkbox"/> 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. <input type="checkbox"/> Please allow student to leave class 10 minutes prior to lunch to manage their diabetes. <input type="checkbox"/> Other:		
PRESCRIBER 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:		
<input type="checkbox"/> I confirm the student has a diagnosis of diabetes mellitus. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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)		
<input type="checkbox"/> Signed by licensed healthcare provider and parent	<input type="checkbox"/> Medication is appropriately labeled	<input type="checkbox"/> Medication log generated
Glucagon is kept: <input type="checkbox"/> NA <input type="checkbox"/> Student Carries <input type="checkbox"/> Backpack <input type="checkbox"/> In Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front Office <input type="checkbox"/> Other:		
Diabetes Emergency Action Plan distributed to 'need to know' staff: <input type="checkbox"/> Teacher(s) <input type="checkbox"/> PE teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Front Office/Admin <input type="checkbox"/> Other (specify):		
School Nurse Signature:	Date:	