

Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

| | | | |
|---|---|-------------------|--------|
| Date of Plan: | This plan is valid for the current school year: | | |
| Student's Name: | Date of Birth: | | |
| Date of Diabetes Diagnosis: | <input type="checkbox"/> type 1 <input type="checkbox"/> type 2 <input type="checkbox"/> Other <input type="checkbox"/> | | |
| School: | School Phone Number: | | |
| Grade: | Homeroom Teacher: | | |
| School Nurse: | Phone: | | |
| CONTACT INFORMATION | | | |
| Mother/Guardian: | | | |
| Address: | | | |
| Telephone: Home: | Work: | Cell: | |
| Email Address: | | | |
| Father/Guardian: | | | |
| Address: | | | |
| Telephone: Home | Work | Cell | |
| Email Address: | | | |
| Student's Physician/Health Care Provider: | | | |
| Address: | | | |
| Telephone: | | | |
| Email Address: | | Emergency Number: | |
| Other Emergency Contacts: | | | |
| Name: | | Relationship: | |
| Telephone Numbers | Home: | Work: | Cell : |

| | |
|---|---|
| CHECKING BLOOD GLUCOSE | |
| Target range of blood glucose: | <input type="checkbox"/> 70-130 mg/dL <input type="checkbox"/> 70-180 mg/dL |
| <input type="checkbox"/> Other: _____ | |
| Check blood glucose level: | <input type="checkbox"/> Before lunch <input type="checkbox"/> ____ Hours after lunch |
| <input type="checkbox"/> 2 hours after a correction dose | <input type="checkbox"/> Mid-morning <input type="checkbox"/> Before PE <input type="checkbox"/> After PE |
| <input type="checkbox"/> Before dismissal | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> As needed for signs/symptoms of low or high blood glucose | |
| <input type="checkbox"/> As needed for signs/symptoms of illness | |
| Preferred site of testing: <input type="checkbox"/> Fingertip <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Other: | |
| Brand/Model of blood glucose meter: _____ | |

Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student or healthcare personnel will dispose of sharps in sharps container in health office, athletic office, or trainer's office. Portable sharps container provided by student on field trips.

Student's self-care blood glucose checking skills:

- Diabetic trained personnel will consult with school nurse, parent, or student's health care provider to confirm appropriate insulin dosage before administration or verification by two trained diabetes personnel.
- Independently checks own blood glucose
- May check blood glucose with supervision
- Requires school nurse or trained diabetes personnel to check blood glucose

Continuous Glucose Monitor (CGM): Yes No

Brand/Model: _____ Alarms set for: (low) and (high)

Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

HYPOGLYCEMIA TREATMENT

Student's usual symptoms of hypoglycemia (list): _____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 10-15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment: _____

HYPOGLYCEMIA TREATMENT (Continued)

Follow physical activity and sports orders (see page 7).

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
- Glucagon: 1mg ½ mg Route: SC IM
- Site for glucagon injection: arm thigh Other: _____
- Call 911 (Emergency Medical Services) and the student’s parents/guardian.

HYPERGLYCEMIA TREATMENT

Student’s usual symptoms of hyperglycemia (list below):

Check Urine Blood for ketones every ___ hour(s) 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 orders below).

For insulin pump users: see additional information for student with insulin pump.

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 page 7).

- Notify parents/guardian of onset of hyperglycemia.
- If the student has symptoms of a hyperglycemia emergency, including dry mouth, shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911 (Emergency Medical Services) and the student’s parents/guardian.

INSULIN THERAPY

Insulin delivery device: syringe insulin pen insulin pump

Type of insulin therapy at school:

- Adjustable Insulin Therapy
- Fixed Insulin Therapy
- No insulin

Adjustable Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:**

Name of insulin: _____

- **Carbohydrate Coverage:**

Insulin-to-Carbohydrate Ratio:

Lunch: 1 unit of insulin per _____ grams of carbohydrate

Snack: 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example

$$\frac{\text{Grams of carbohydrates in meal}}{\text{Insulin-to-carbohydrate ratio}} = \text{_____ units of insulin}$$

- **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____

Target blood glucose = _____ mg/dL

Correction Dose Calculation Example

$$\frac{\text{Actual Blood Glucose}-\text{Target Blood Glucose}}{\text{Blood Glucose Correction Factor/Insulin Sensitivity Factor}} = \text{_____ units of insulin}$$

Correction dose scale (use instead of calculation above to determine insulin correction dose):

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

INSULIN THERAPY

When to give insulin:

Lunch

Carbohydrate coverage only

Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

Other: _____

INSULIN THERAPY (Cont'd)

Snack

- No coverage for snack
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- Other: _____

- Correction dose only:
For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.
- Other: _____

Fixed Insulin Therapy

- Name of insulin: _____
- _____ Units of insulin given pre-lunch daily
- _____ Units of insulin given pre-snack daily
- Other: _____

Parental Authorization to Adjust Insulin Dose:

- Yes No Parents/guardian authorization should be obtained before administering a correction dose.
- Yes No Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.
- Yes No Parents/guardian are authorize to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate.
- Yes No Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

Student's self-care insulin administration skills:

- Yes No Independently calculates and gives own injections
- Yes No May calculate/give own injections with supervision
- Yes No Requires school nurse or trained diabetes personnel to calculate/give injections
- Yes No Trained diabetes care aide

ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP

Brand/Model of pump: _____ Type of insulin in pump: _____

Basal rates during school: _____

Type of infusion set: _____

- For blood glucose greater than _____ mg/dL that has not decreased within _____ hours correction, consider pump failure or infusion site failure. Notify parents/guardian.
- For infusion site failure: Insert new infusion set and/or replace reservoir.
- For suspected pump failure: suspend or remove pump and give insulin by syringe or pen.

Physical Activity

May disconnect from pump for sports activities Yes No
 Set a temporary basal rate Yes No _____ % temporary basal for _____ hours
 Suspend pump use Yes No

Student's self-care pump skills:

Independent?

- Count carbohydrates Yes No
- Bolus correct amount for carbohydrates consumed Yes No
- Calculate and administer correction bolus Yes No
- Calculate and set basal profiles Yes No
- Calculate and set temporary basal rate Yes No
- Change batteries Yes No
- Disconnect pump Yes No
- Reconnect pump to infusion set Yes No
- Prepare reservoir and tubing Yes No
- Insert infusion set Yes No
- Troubleshoot alarms and malfunctions Yes No

OTHER DIABETES MEDICATIONS

Name: _____ Dose: _____ Route: _____ Times given: _____
 Name: _____ Dose: _____ Route: _____ Times given: _____

MEAL PLAN

| Meal/Snack | Time | Carbohydrate Content (grams) |
|--|------|------------------------------|
| 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 provided to the class (e.g., as part of a class party or food sampling event): _____ _____ | | |

Special event/party food permitted: Parents/guardian discretion Student discretion

Student's self-care nutrition skills:

- Yes No Independently counts carbohydrates
- Yes No May count carbohydrates with supervision
- Yes No Requires school nurse/trained diabetes personnel to count carbohydrates

PHYSICAL ACTIVITY AND SPORTS

A quick-acting source of glucose such as glucose tabs and/or sugar-containing juice must be available at the site of physical education activities, sports, and field trips.

Student should eat 15 grams 30 grams of carbohydrate other _____

before every 30 minutes during after vigorous physical activity

other _____

If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

(Additional information for student on insulin pump is in the insulin section on page 6).

DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.

Continue to follow orders contained in this DMMP.

Additional insulin orders as follows: _____

Other: _____

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider Date _____

I, (parent/guardian) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) _____ to perform and carry out the diabetes care tasks as outlined in (student) _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian _____ Date _____

Student's Parent/Guardian _____ Date _____

School Nurse/Other Qualified Health Care Personnel _____ Date _____

Trained Diabetic Aide _____ Date _____