Cherry Hill Public Schools

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. (adapted from www.YourDiabetesInfo.org Helping the Student with Diabetes Succeed)

Date of Plan: _____ School year: _____ - _____
Student's Name: _____ Date of Birth: _____
Date of Diabetes Diagnosis: _____ ☐ type 1 ☐ type 2 ☐ Other_____
School: _____ School Phone Number: _____
Grade: _____ Homeroom/Team/LC: _____
School Nurse: _____ Phone: _____

CONTACT INFORMATION

1. Parent/Guardian: _____
Address: _____
Parent/guardian contact number 1: _____
Parent/guardian contact number 2: _____
Email Address: _____

2. Parent/Guardian: _____
Address: _____
Parent/guardian contact number 1: _____
Parent/guardian contact number 2: _____
Email Address: _____

Student's Physician/Health Care Provider: _____
Address: _____
Telephone: _____
Email Address: _____

Other Emergency Contacts:
Name: _____ Relationship: _____
Contact number: _____

CHECKING BLOOD GLUCOSE

Target range of blood glucose: □ 70–130 mg/dL □ 70–180 mg/dL
□ Other: _____
Check blood glucose level: □ Before lunch □ _____ Hours after lunch
□ 2 hours after a correction dose □ Mid-morning □ Before PE □ After PE
□ before dismissal □ Other: _____
□ As needed for signs/symptoms of low or high blood glucose
□ As needed for signs/symptoms of illness
Preferred site of testing: □ Fingertip □ Forearm □ Thigh □ Other: _____
Brand/Model of blood glucose meter:_____
Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

□ 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)
Use CGM for insulin coverage: □ Yes □ No
Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If the student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardLess of CGM.

HYPOGLYCEMIA TREATMENT

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

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: _____

Follow physical activity and sports orders (see page 6).

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
- Glucagon: □ 1 mg □ 1/2 mg Route: □ SC □ IM
- Site for glucagon injection: □ arm □ thigh □ Other: _____
- Intranasal Glucagon: _____

- Call 911 (Emergency Medical Services) and the student's parents/guardian.
- Contact the student's health care provider.

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 orders below)

For insulin pump users: see additional information for students with insulin pump on page 5-6.

Give extra water and/or *non-sugar-containing* drinks:____ ounces per hour
Additional treatment for ketones: _____

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

- Notify parent/guardian of onset of hyperglycemia.
- If the student has symptoms of a hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing, shortness of breath, chest pain, increasing sleepiness or lethargy, depressed level of consciousness: Call 911 (Emergency Medical Services) and the student's parent/guardian.
- Contact the student's health care provider.

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

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

- **Correction Dose:**
  Blood Glucose Correction Factor/Insulin Sensitivity Factor= _____
  Target blood glucose = _____mg/dL

Correction Dose Calculation Example

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

Correction dose scale:
(use instead of calculation above to determine correct insulin 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 (Continued)
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: _____
Snack:
□ No coverage for snack
□ Carbohydrate coverage only
□ Carbohydrate coverage plus correction dose when blood 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 authorized 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.

INSULIN THERAPY (Continued)

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.

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 after correction, consider pump failure or infusion site failure. Notify parent/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/Sports

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: □ Parent/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 and sports.
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 a student on insulin pump is in the insulin section on page 5-6.)

DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 HOURS), obtain an 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 healthcare 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 healthcare professional to contact my child's physician/health care provider. We understand that the Cherry Hill Public School District shall incur no liability as a result of any injury arising from the above medical management plan. We further acknowledge that we understand that any person who acts in good faith in accordance with the requirements of law shall be immune from any civil or criminal liability arising from actions performed pursuant to this request.

Acknowledged and received by:

Student's parent/guardian: _____ Date:____

Student's parent/guardian: _____ Date:____

School Nurse: _____ Date: ____