## 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 <a href="www.YourDiabetesInfo.org">www.YourDiabetesInfo.org</a> Helping the Student with Diabetes Succeed)

Date of Plan:	School year:			
	Date of Birth:			
Date of Diabetes Diagnosis:	□ type 1 □ type 2 □ Other			
School:	School Phone Number:			
Grade: Homeroom/Team/LC:				
	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 Pr	rovider:			
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 Check blood glucose level: □ Before lunch □ Hours after lunch □ 2 hours after a correction dose □ Mid-morning □ Before PE □ After PE □ before dismissal □ Other: $\hfill\Box$ 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: $\Box$ (low) and $\Box$ (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: $\Box$ 1 mg $\Box$ 1/2 mg Route: $\Box$ SC $\Box$ IM • 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 everyhours when blood glucose levels are abovemg/dL.
For blood glucose greater thanmg/dL AND at leasthours 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 <i>non-sugar-containing</i> drinks: ounces per hour  Additional treatment for ketones:
<ul> <li>Follow physical activity and sports orders (see page 7).</li> <li>Notify parent/guardian of onset of hyperglycemia.</li> <li>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.</li> <li>Contact the student's health care provider.</li> </ul>
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
<ul> <li>Carbohydrate Coverage/Correction Dose: Name of insulin: </li> <li>Carbohydrate Coverage: Insulin-to-Carbohydrate Ratio: Lunch: 1 unit of insulin per grams of carbohydrate Snack: 1 unit of insulin per grams of carbohydrate </li> </ul>

Carbohydrate Dose Calculation Example
Grams of carbohydrate in meal
Insulin-to-carbohydrate ratio = units of insulin
Correction Dose:  Blood Glucose Correction Factor/Insulin Sensitivity Factor=  Target blood glucose =mg/dL
Correction Dose Calculation Example
Actual Blood Glucose - Target Blood Glucose
Blood Glucose Correction Factor/Insulin Sensitivity Factor
Correction dose scale:  (use instead of calculation above to determine correct insulin dose)  Blood glucose tomg/dL give units  Blood glucose tomg/dL give units
INSULIN THERAPY (Continued)
When to give insulin:  Lunch:  Carbohydrate coverage only  Carbohydrate coverage plus correction dose when blood glucose is greater thanmg/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 thanmg/dL and hours since last insulin dose.
□ Other:
since last insulin dose.
□ Other:

<b>Fixed Insulir</b> Name of insu	
	sulin given pre-lunch daily
	sulin given pre-snack daily
	diffi given pre shaek dany
	<del></del>
Parental Aut	thorization to Adjust Insulin Dose:
□ Yes □ No	Parents/guardian authorization should be obtained before administering a correction dose.
$\square \ Yes \ \square \ No$	Parents/guardian are authorized to increase or decrease
	correction dose scale within the following range: +/ units of insulin.
$\square$ Yes $\square$ 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.
$\square$ Yes $\square$ No	Parents/guardian are authorized to increase or decrease
	fixed insulin dose within the following range: +/ units of insulin.
INSULIN TI	HERAPY (Continued)
Student's sel	f-care insulin administration skills:
□ Yes □ No	Independently calculates and gives own injections
$\square \ Yes \ \square \ No$	May calculate/give own injections with supervision
$\square$ Yes $\square$ No	Requires school nurse or trained diabetes personnel to
	calculate /give injections.
ADDITION	AL INFORMATION FOR STUDENT WITH INSULIN PUMP
Brand/Model	of pump:
Type of insul	in in pump:
Basal rates du	rring school:
Type of infus	ion set:
Di F 11	
	ood glucose greater than mg/dL that has not decreased within
	after correction, consider pump failure or infusion site failure. Notify
•	ts/guardian. fusion site failure: Insert new infusion set and/or replace reservoir.
	spected pump failure: suspend or remove pump and give insulin by syringe or pen
_ 10130	er

Physical Acti	vity/Sports			
May disconne	ct from pump for spor	ts activities $\Box$ Y	es □ No	
Set a temporary basal rate $\Box$ Yes $\Box$ No% temporary basal for hours				
Suspend pump	o use □ Yes □ No			
Student's self	f-care pump skills:		Independent?	
Count carbohy			□ Yes □ No	
Bolus correct amount for carbohydrates consumed		ates consumed	□ Yes □ No	
Calculate and administer correction bolus		bolus	□ Yes □ No	
Calculate and set basal profiles			□ Yes □ No	
Calculate and set temporary basal rate		te	□ Yes □ No	
Change batteries			□ Yes □ No	
Disconnect pump			□ Yes □ No	
Reconnect pump to infusion set			□ Yes □ No	
Prepare reserv	oir and tubing		□ Yes □ No	
Insert infusion	<del>-</del>		□ Yes □ No	
Troubleshoot	alarms and malfunctio	ns	$\square$ Yes $\square$ No	
OTHER DIA	BETES MEDICATION	ONS		
Name:	Dose:	Route:	Times given:	
	Dose:			
MEAL PLAN	V			
Meal/Snack	Time	Carbohydr	ate Content (gram	s)
Breakfast			_ to	
Mid-morning	snack		_to	
Lunch			to	
Mid-afternoor	n snack		to	
Other times to	give snacks and conte	ent/amount:		
Instructions for event):	or when food is provide	ed to the class (e.g.,	as part of a class par	ty or food sampling
Special event/	party food permitted:	□ Parent/guardian o □ Student discretion		
Student's self	foore nutrition skills:			
	Student's self-care nutrition skills:			
	Independently counts carbohydrates  May count carbohydrates with supervision			
	3			
☐ Yes ☐ No Requires school nurse/trained diabetes personnel to count carbohydrates				

## PHYSICAL ACTIVITY AND SPORTS

-	ick-acting source of glucose such as $\Box$ glucose tabs and/or $\Box$ sugar-containing juice must be able at the site of physical education activities and sports.
Stude	ent should eat □ 15 grams □ 30 grams of carbohydrate □ other
	fore $\square$ every 30 minutes during $\square$ after vigorous physical activity her
	ost recent blood glucose is less than mg/dL, student can participate in physical ity when blood glucose is corrected and above mg/dL.
	d physical activity when blood glucose is greater than mg/dL or if urine/ blood nes are moderate to large.
(Add	litional information for a student on insulin pump is in the insulin section on page 5-6.)
DISAS	STER PLAN
•	repare for an unplanned disaster or emergency (72 HOURS), obtain an emergency ly kit from parent/guardian.
	Continue to follow orders contained in this
	DMMP
	Additional insulin orders as follows:
	Other:

## Signatures:

This Diabetes Medical Management P	lan has been approved by:	Student's			
Physician/Health Care Provider	Date	Student 3			
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:			