

Diabetes Medical Management Plan (DMMP)

Adapted from Helping the Student with Diabetes Succeed: A Guide for School Personnel (2016)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. 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 information

Student's name: _____ Date of birth: _____

Date of diabetes diagnosis: _____

___Type 1 ___Type 2 Other: _____

School: _____ School phone number: _____

Grade: _____ Homeroom teacher: _____

School nurse: _____ Phone: _____

Bus number: _____ OR Parent Transport _____

Contact information

Parent/Guardian 1: _____

Address: _____

Telephone: Home: _____

Work: _____

Cell: _____

Email address: _____

Parent/Guardian 2: _____

Address: _____

Telephone: Home: _____

Work: _____

Cell: _____

Email address: _____

Student's physician/health care provider: _____

Address: _____

Telephone: Work: _____

Emergency number: _____

Email address: _____

Other emergency contacts:

Name: _____ Relationship: _____

Telephone: Home: _____

Work: _____

Cell: _____

Checking blood glucose

Brand/model of blood glucose meter: _____

Target range of blood glucose:

Before meals: ___ 90–130 mg/dL Other: _____

Check blood glucose level:

___ Before breakfast ___ After breakfast ___ Hours after breakfast

___ 2 hours after a correction dose ___ Before lunch

___ After lunch ___ Before dismissal ___ Hours after lunch

___ Mid-morning ___ Before PE ___ After PE

___ Before recess ___ After recess

Other: _____

___ As needed for signs/symptoms of low or high blood glucose

___ As needed for signs/symptoms of illness

Preferred site of testing: ___ Side of fingertip Other: _____

Note: The side of 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 a school nurse or trained diabetes personnel to check blood glucose

___ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM): ___ Yes ___ No

Brand/model: _____

Alarms set for: Severe Low: _____ Low: _____ High: _____

Predictive alarm: Low: _____ High: _____

Rate of change: Low: _____ High: _____

Threshold suspend setting: _____

Additional information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level. If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-care CGM Skills	Independent?	
The student troubleshoots alarms and malfunctions.	☐ Yes	☐ No
The student knows what to do and is able to deal with a HIGH alarm.	☐ Yes	☐ No
The student knows what to do and is able to deal with a LOW alarm.	☐ Yes	☐ No
The student can calibrate the CGM.	☐ Yes	☐ No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ Yes	☐ No

The student should be escorted to the nurse if the CGM alarm goes off.

Other instructions for the school health team:

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.

Notify parents/guardian if blood glucose is under _____ mg/dL.

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

Additional treatment:

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

Position the student on his or her side to prevent choking.

Give glucagon: __1 mg __ ½ mg Other (dose) _____

Route: __Subcutaneous (SC) __Intramuscular (IM)

Site for glucagon injection: __Buttocks __Arm __Thigh

Other: _____

If student has an insulin pump, disconnect or suspend.

Call 911 (Emergency Medical Services) and the student's parents/guardians.

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 correction dose orders).

Notify parents/guardians if blood glucose is over _____ mg/dL.

Allow unrestricted access to the bathroom.

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.

If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy or depressed level of consciousness.

Insulin therapy

Insulin delivery device: ___Syringe ___Insulin pen ___Insulin pump

Type of insulin therapy at school: ___Adjustable (basal-bolus)

insulin ___Fixed insulin therapy ___No insulin

Insulin therapy *Continued***Adjustable (Basal-bolus) Insulin Therapy****Carbohydrate Coverage/Correction Dose:**

Name of insulin: _____

Carbohydrate Coverage:**Insulin-to-carbohydrate ratio:****Breakfast:** 1 unit of insulin per _____ grams of carbohydrate**Lunch:** 1 unit of insulin per _____ grams of carbohydrate**Snack:** 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example	
$\frac{\text{Total Grams of Carbohydrate to Be Eaten}}{\text{Insulin-to-Carbohydrate Ratio}} = \text{Units of Insulin}$	

Correction dose: Blood glucose correction factor (insulin sensitivity factor) = _____ Target blood glucose = _____ mg/dL

Correction Dose Calculation Example	
$\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Correction Factor}} = \text{Units of Insulin}$	

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

See the worksheet examples in Advanced Insulin Management: Using Insulin-to-Carb Ratios and Correction Factors for instructions on how to compute the insulin dose using a student's insulin-to-carb ratio and insulin correction factor.

When to give insulin:

Breakfast

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

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.
- ☐ 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-breakfast daily
- _____ Units of insulin given pre-lunch daily
- _____ Units of insulin given pre-snack daily
- Other: _____

Student's self-care insulin administration skills:

- ☐ Independently calculates and gives own injections.
 - ☐ May calculate/give own injections with supervision.
 - ☐ Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.
 - ☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection.
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Additional information for student with insulin pump

Brand/model of pump: _____

Type of insulin in pump: _____

Basal rates during school:

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Other pump instructions:

Type of infusion set: _____

Appropriate infusion site(s): _____

___For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.

___For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.

___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, for _____ hours

___No

Set a temporary basal rate: Yes, _____ % temporary basal for _____ hours ___No

Suspend pump use: Yes, for _____ hours ___No

Student's Self-care Pump Skills	Independent?	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots 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:

☐ Independently counts carbohydrates

☐ May count carbohydrates with supervision

☐ 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 ___ every 60 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.

Disaster Plan

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

___ Continue to follow orders contained in this DMMP.

___ Additional insulin orders as follows (e.g., dinner and nighttime):

___ Other: _____

Trained Diabetes Personnel

If the school chooses to designate nonmedical school staff as trained diabetes personnel for this student, they may administer the following medications:

___ Insulin

___ Glucagon

___ Other (please specify): _____

Signatures

This Diabetes Medical Management Plan (DMMP) 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) _____ DMMP. I also consent to the release of the information contained in this DMMP to all school staff members and other adults who have responsibility for this student and who may need to know this information to maintain my student's health and safety. I also give permission to the school nurse to contact my student's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian Date

Student's Parent/Guardian Date

Certified School Nurse Date

