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: _____ ☐ type 1 ☐ type 2 ☐ Other_____

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: _____

_____ _____

Other Emergency Contacts:

Name: Relationship:_____

Telephone: Home Work Cell:_____

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)

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 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: _____

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: ☐ 1 mg ☐ 1/2 mg Route: ☐ SC ☐ IM

Site for glucagon injection: ☐ arm ☐ thigh ☐ Other: _____

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

Contact 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 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, 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: Call 911 (Emergency Medical Services) and the student's parents/guardian.

Contact 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

Grams of carbohydrate in meal _____ units of insulin
Insulin-to-carbohydrate ratio

Correction Dose:

Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____

Target blood glucose = _____ mg/dL

Correction Dose Calculation

Example ***Actual Blood Glucose—Target Blood Glucose*** = _____ units of insulin
Blood Glucose Correction Factor/Insulin Sensitivity Factor

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 (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 skill

☐ 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 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 (gram
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 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 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

School Nurse/Other Qualified Health Care Personnel

Date