

# 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: \_\_\_\_\_

Email Address: \_\_\_\_\_ Emergency Number: \_\_\_\_\_

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**

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

- **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor = \_\_\_\_\_

Target blood glucose = \_\_\_\_\_ mg/dL

**Correction Dose Calculation Example**

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

Correction dose scale (use instead of calculation above to determine 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 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 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                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bolus correct amount for carbohydrates consumed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and administer correction bolus       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set basal profiles                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set temporary basal rate          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Change batteries                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Disconnect pump                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Reconnect pump to infusion set                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prepare reservoir and tubing                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insert infusion set                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Troubleshoot alarms and malfunctions            | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 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 Date

\_\_\_\_\_  
School Nurse/Other Qualified Health Care Personnel Date