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**Diabetes Medical Management Plan (DMMP)**

This plan should be completed by the student’s personal diabetes health care team, including the primary doctor and 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 doctor and nurses 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:

**Diabetes Medical Management Plan (DMMP) — Page 2**

**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.

**Diabetes Medical Management Plan (DMMP) — Page 3 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.

**Diabetes Medical Management Plan (DMMP) — page 4**

**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***  ***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***

Correction dose scale (use instead of calculation above to determine insulin correction dose):

***Blood Glucose Correction Factor/Insulin Sensitivity Factor***

= \_\_\_\_\_\_\_units of insulin

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 |
|  |  |  |  |  |

**Diabetes Medical Management Plan (DMMP) — page 5 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.

**Diabetes Medical Management Plan (DMMP) — page 6 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

**Diabetes Medical Management Plan (DMMP) — page 7**

**OTHER DIABETES MEDICATIONS**

Name: Dose: Route: Times given: \_\_\_\_\_\_

Name: Dose: Route: Times given: \_\_\_\_\_\_

**Meal/Snack Time Carbohydrate Content (grams)**

Breakfast \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ to

Mid-morning snack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ to

Lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ to

Mid-afternoon snack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ to

**MEAL PLAN**

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.)

**Diabetes Medical Management Plan (DMMP) — page 8**

**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 doctor  
or another qualified health care professional at 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 doctor or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian

Date

Date

Date

Student's Parent/Guardian

School Doctor/School Nurse