

Diabetes Medical Management Plan (DMMP)

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: _____
Grade: _____
Homeroom teacher: _____
School phone number: _____
Phone: _____

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: _____
Emergency number: _____
Email address: _____
Other emergency contacts:
Name: _____
Relationship: _____
Telephone: Home: _____ Work: _____ Cell: _____





Other instructions for the school health team:

The student should be escorted to the nurse if the CGM alarm goes off: Yes No

Students Self-care CGM Skills		Independent?
The student troubleshoots alarms and malfunctions.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
The student knows what to do and is able to deal with a HIGH alarm.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
The student knows what to do and is able to deal with a LOW alarm.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
The student can calibrate the CGM.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- 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.

Additional information for student with CGM

Threshold suspend setting: _____

Predictive alarm: Low: _____ High: _____ Rate of change: Low: _____ High: _____

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

Continuous glucose monitor (CGM): Yes No Brand/model: _____

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

Requires a school nurse or trained diabetes personnel to check blood glucose

May check blood glucose with supervision

Independently checks own blood glucose

Student's self-care blood glucose checking skills:

Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Preferred site of testing: Side of fingertip Other: _____

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

As needed for signs/symptoms of illness

Mid-morning Before PE After PE

Before lunch After lunch Hours after lunch

Before breakfast After breakfast Hours after breakfast 2 hours after a correction dose

Check blood glucose level: _____

Before meals: 90-130 mg/dL Other: _____

Target range of blood glucose: _____

Brand/model of blood glucose meter: _____

Checking blood glucose



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

• Follow physical activity and sports orders. (See **Physical Activity and Sports**)

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.

Additional treatment for ketones:

- Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.
- Allow unrestricted access to the bathroom.
- For insulin pump users: see **Additional Information for Student with Insulin Pump**.
- Notify parents/guardians if blood glucose is over _____ mg/dL.
- Insulin (see correction dose orders).
- For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose, give correction dose of _____ mg/dL.
- Check Urine Blood for ketones every _____ hours when blood glucose levels are above _____ mg/dL.

Hyperglycemia treatment

Student's usual symptoms of hyperglycemia (list below): _____

- Position the student on his or her side to prevent choking.
 - Give glucagon: 1 mg ½ mg Other (dose) _____
 - Route: Subcutaneous (SC) Intramuscular (IM) Other: _____
 - Site for glucagon injection: Buttocks Arm Thigh Other: _____
 - Call 911 (Emergency Medical Services) and the student's parents/guardians.
 - Contact the student's health care provider.
- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements):

Additional treatment:

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

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.

Hypoglycemia treatment

Student's usual symptoms of hypoglycemia (list below): _____

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

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

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

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

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

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

insulin dose.

Lunch

Carbohydrate coverage only

insulin dose.

Snack

No coverage for snack

Carbohydrate coverage only

insulin dose.

Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last
 Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL AND at least _____ hours since last insulin dose.
 Correction dose only: For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.
 Other: _____



Insulin therapy (continued)

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: _____

Parents/Guardians Authorization to Adjust Insulin Dose

Yes No Parents/guardians authorization should be obtained before administering a correction dose.

Yes No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.

Yes No Parents/guardians 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/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

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.

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: _____

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



National Diabetes Education Program

A program of the National Institutes of Health and the Centers for Disease Control and Prevention



- Requires school nurse/trained diabetes personnel to count carbohydrates
- May count carbohydrates with supervision
- Independently counts carbohydrates

Student's self-care nutrition skills:

Special event/party food permitted: Parents'/Guardians' discretion Student discretion

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): _____

Other times to give snacks and content/amount: _____

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast	_____ to _____	_____ to _____
Mid-morning snack	_____ to _____	_____ to _____
Lunch	_____ to _____	_____ to _____
Mid-afternoon snack	_____ to _____	_____ to _____

Meal plan

Name: _____ Dose: _____ Route: _____ Times given: _____

Name: _____ Dose: _____ Route: _____ Times given: _____

Other diabetes medications

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

Additional information for student with insulin pump (continued)



School Nurse/Other Qualified Health Care Personnel _____ Date _____

Students' Parent/Guardian _____ Date _____

Students' Parent/Guardian _____ Date _____

Acknowledged and received by:

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) _____ 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.

Students' Physician/Health Care Provider _____ Date _____

This Diabetes Medical Management Plan has been approved by:

Signatures

Other: _____

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

Continue to follow orders contained in this DMMP.

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

Disaster plan

(See **Administer Insulin** for additional information for students on insulin pumps.)

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

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.

before every 30 minutes during every 60 minutes during after vigorous physical activity other: _____

Student should eat 15 grams 30 grams of carbohydrate other: _____

of physical education activities and sports.

A quick-acting source of glucose such as glucose tabs and/or sugar-containing juice must be available at the site

Physical activity and sports