Student Name: _____ Student DOB: _____

National Diabetes Education Program

American Diabetes Association.

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: _____

Fax Number: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____ Relationship:_____

Telephone: Home _____ Work _____ Cell:_____

Student Name: _____ Student DOB: _____

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 by trained non-medical personnel

☐ 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 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.

HYPERGLYCEMIA TREATMENT

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

_____

_____

Check urine for ketones every _____ hours when blood glucose levels are above _____ mg/dL. If ketones are present, parents will be called and student must go home. Student will stay in health office until student is picked up.

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

- Notify parents/guardian of onset of hyperglycemia when blood glucose levels are above _____mg/dL.
- 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.

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

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

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 skill for students with INSULIN PUMPS:

☐ Yes ☐ No	Student independently operates pump and DOES NOT need to come to health office for diabetic care when they are in their target blood glucose range.
☐ Yes ☐ No	Student independently calculate carbohydrates and operate pump but needs to come to health office for all diabetic care for supervision by trained non-medical personnel.
☐ Yes ☐ No	Student requires trained non-medical personnel to calculate carbohydrates but can operate pump on their own.
☐ Yes ☐ No	Student requires trained non-medical personnel to calculate carbohydrates and operate pump.
☐ Yes ☐ No	Student requires licensed nurse to assist with all diabetes care, including carbohydrate calculations and operating pump because student is unable to do so independently.

Student's self-care insulin administration skill for students with INSULIN INJECTIONS OR PENS:

☐ Yes ☐ No	Student independently calculates carbohydrates, insulin dose, and gives injections without supervision. Student is not required to come to the health office for diabetic care when they are in their target blood glucose range, except for sharps disposal.
☐ Yes ☐ No	Student independently calculates carbohydrates, insulin dose, and gives injections but is required to come to the health office for all diabetic care for supervision by trained non-medical personnel.
☐ Yes ☐ No	Student requires trained non-medical personnel to calculate carbohydrates and insulin dose, based on sliding scale, but can prepare and administer injections on their own.
☐ Yes ☐ No	Student requires licensed nurse to assist with all diabetes care, including carbohydrate calculations, insulin dose based on sliding scale, and insulin preparation and administration because student is unable to do so independently.

OTHER FOOD AT SCHOOL

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 via phone call
☐ Student discretion

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.

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: _____

Medical Management Plan (DMMP) — page 8

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

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

_____

Student's Physician/Health Care Provider Date

Care Plan Reviewed and Approved By:
District Registered
Nurse: _____ Date: _____

Parent/Guardian Consent for Management of Health Condition at School

I, the parent or guardian of the above named student, request that this School Health Care Plan be used to guide care for my child during school hours. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with the primary care provider/specialist about this health condition, including signing a separate Authorization for Release of Information form as needed.
5. Consent that school staff interacting directly with my child may be informed about his/her special needs while at school and receive a copy of this care plan and instruction from the school nurse about it.
6. Submit medication authorization forms if student is to have medication administered at school.

Parent/Guardian: _____ Date: _____