Diabetes Medical Management Plan (DMMP)

To be completed by parent/guardian and the health care team. This document should be reviewed with necessary school staff and kept with the student's school records.

Date of Plan_____ School Year_____ School_____ Teacher_____
Student Name_____ Birthdate _____ Grade _____
Date of Diabetes Diagnosis _____ [ ] Type 1 [ ] Type 2 [ ] Other _____
Doctor/Health Care Provider _____ Phone Number _____ Fax Number _____
Ophthalmologist _____ Phone Number_____ Fax Number _____
Parent/guardian #1:_____ Home # _____Cell #_____ Work # _____
Address: _____ Email Address _____
Parent/guardian #2:_____ Home # _____Cell#_____ Work # _____
Address: _____ Email Address _____
Other emergency contact:

Name	Relationship to Student	Contact Numbers
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. BLOOD GLUCOSE

Type of Blood Glucose Meter _____ ***Note****: The fingertip should always be used to check blood. glucose level if hypoglycemia is suspected*
Target range for blood glucose: _____mg/dl to _____mg/dl

Check Blood Glucose Level:
[ ] Before Lunch [ ]___Hours After Lunch [ ] 2 Hours After a Correction Dose
[ ] Midmorning [ ] Before Exercise [ ] After Exercise
[ ] As needed for s/s of low or high blood glucose [ ] As needed for Illness
[ ] Before Dismissal [ ] Other _____

Continuous Glucose Monitoring (CGM): [ ] Yes [ ] No Type _____ Alarms set for [ ] low and/or [ ] high

Note: Confirm CGM results with blood glucose meter before taking action on sensor blood glucose level. If student has s/s of hypoglycemia, check fingertip blood glucose level regardless of GCM.

2. 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 Name of Insulin _____

- 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

$$\frac{\text{Grams of carbohydrate consumed}}{\text{Insulin-to-carbohydrate ratio}} = \text{\_\_\_\_\_ units of insulin}$$

- Carbohydrate Coverage/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

BG Correction Factor/Insulin Sensitivity Factor

Correction Dose Scale (Sliding 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

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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

- When to give adjustable Insulin Therapy
  - Lunch
    [ ] Carbohydrate coverage only [ ] Carbohydrate coverage plus correction dose and ____hours since last insulin dose
    [ ] Other _____
  - Snack
    [ ] Carbohydrate coverage only [ ] Carbohydrate coverage plus correction dose and ____hours since last insulin dose
    [ ] No coverage for snack [ ] 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 and _____hours and since last insulin dose.

[ ] 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 and administer correction dose scale within the following range: +/- _____units of insulin.

[ ] Yes [ ] No Parents/guardian are authorized to increase or decrease and administer insulin-to-carbohydrate ratio within the following range: _____units per prescribed grams of carbohydrate, =/- ____grams of carbohydrates.

[ ] Yes [ ] No Parents/guardian are authorized to increase or decrease and administer fixed insulin dose within the following range: =/- ____units of insulin.

3. 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/guardians.

[ ] 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

[ ] Yes [ ] No May disconnect from pump for sports activities

[ ] Yes [ ] No Set a temporary basal rate _____% temporary basal for _____hours

[ ] Yes [ ] No Suspend pump use

Meals and Snacks

Meal and snack times:	Time	Carbohydrate Content (grams):
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Other	_____	_____

Special event/party food permitted: [ ] Parent/guardian discretion [ ] Student discretion

4. 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 carbohydrates [ ] other _____
[ ] before [ ] every 30 minutes during [ ] after rigorous physical activity

Restrictions on activity, if any: _____

Child should not exercise if blood glucose is below _____ mg/dl.

5. HYPOGLYCEMIA (Low blood sugar) and HYPERGLYCEMIA (high blood sugar)

See attached hypoglycemia and hyperglycemia protocol/emergency plan.

[Glucagon should be given if child is unable to eat or drink, is unconscious or unresponsive, or having a seizure (convulsion). If glucagon is given, call 911 (or other emergency assistance, school nurse and parents immediately.]

I, _____give permission to the school nurse or another qualified health care professional or trained diabetes personnel of _____to perform and carry out the diabetes care tasks as outlined in _____'s Diabetes Medical Management Plan (DMMP). 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.

_____ _____ _____ _____

Parent/Guardian Date Witness Date

Signature of School Nurse _____ Date_____

Acknowledged/received by: _____ Date_____

(Parent/guardian)

_____ Date _____

(Qualified School Health Care Personnel)

_____ Date _____

(Qualified School Health Care Personnel)

_____ Date _____

(Qualified School Health Care Personnel)

Hypoglycemia and Hyperglycemia Protocol/Emergency Plan	
Hypoglycemia (signs of low blood sugar)	***Hyperglycemia (signs of high blood sugar)***
Irritability or combative Sweating and shaky Fatigue or headache Sudden Hunger Shakiness or nervousness Confusion or poor concentration Drowsiness or dizziness Paleness Inappropriate action	Extreme thirst, hunger or urination Blurry vision Fatigue Behavior changes Inability to concentrate Nausea or vomiting
Treatment for Hypoglycemia	***Treatment for Hyperglycemia***
1. Follow any MD orders for treatment for student in the DMMP on campus or school related activities 2. Check blood sugar level with student meter or if no meter but student has symptoms treat for low blood sugar. Contact the school nurse 3. Give 15 grams of fast acting carbohydrate such as: • ½ can regular soda • 4-6 oz. of orange juice • glucose tablets • follow student DMMP 4. Stay with student and repeat treatment if necessary after re-checking blood sugar level with meter in 15 min and follow treatment with a snack, lunch, or DMMP 5. If student found unresponsive call 911 and follow orders for individual DMMP *(glucagon medication or glycol-Gel)*	1. Follow student DMMP and notify parent/guardian 2. Encourage student to drink 8 -16 oz. of water 3. Contact school nurse or trained unlicensed diabetic assisyant to retest blood sugar level in 30 min and treat using student's DMMP 4. Test urine for Ketones using ketosticks 5. Contact MD if any question or concerns

Emergency Treatment Plan for Diabetes

Name of Student_____ Teacher_____

Grade_____ School_____

Name of Parent / Guardian_____

Phone Numbers: Home _____ Work _____ Beeper_____

Alternate Adult Contact Person: (1) _____
Phone#_____

Alternate Adult Contact Person: (2) _____
Phone#_____

Relationship of alternate persons to student: (1)_____(2)_____

Physician's Name _____ Phone Number_____

Ambulance Choice: _____

Hospital Choice: _____

E.R. Numbers: _____

Poison Control Number: 1-800-256-9822

Student's allergy history: _____

_____

(List all medications, food, plants, insects, etc. that your child is allergic to)

Field Trip Designated Person: Trained Personnel_____, or
Parent/Guardian_____

I am aware that if my child has an emergency in school and I am not available, the school Principal or alternate will have my child transported to the emergency room, and I will be responsible for payment of emergency care.

_____ _____

Parent/Guardian Signature Date