DIABETES MEDICAL MANAGEMENT PLAN (DMMP)

School Plan for a Child with Diabetes

Completed by the Student's Diabetes Healthcare Team
(Parents/Guardian, School Nurse, Physician & Child if Age Appropriate)

Date of Plan: _____ **Plan is Valid for Current School Year** 20_____ - 20_____.

STUDENT INFORMATION

Student's Name: _____ **Date of Birth:** _____
Date of Diabetes Diagnosis: _____
- ☐ Type 1
- ☐ Type 2
- ☐ Other _____

Parent/Guardian 1:_____
Cell Phone #: _____ Work: _____
Parent/Guardian 2: _____
Cell Phone #: _____ Work: _____
Other Emergency Contacts:
Name: _____ Relationship: _____
Cell phone #: _____ Work: _____
Name: _____ Relationship: _____
Cell phone #: _____ Work: _____

BLOOD GLUCOSE TESTING

Brand/Model of blood glucose meter: _____
Target range of blood glucose: _____

Check blood glucose level:
- ☐ Before Lunch
- ☐ Before PE
- ☐ After PE
- ☐ 2 hours after correction dose.
- ☐ As needed for signs/symptoms of low or high blood glucose or illness.
- ☐ Before Dismissal
- ☐ Bus Ride Parameters: _____
  _____
- ☐ Other _____

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No
If yes, Brand/Model: _____
Alarms set for: Severe low: #_____ Low: #_____ High: #_____

Student's self-care blood glucose checking skills:

- ☐ Independently checks own blood glucose.
- ☐ May check blood glucose with supervision.
- ☐ May carry glucometer and check blood glucose wherever and whenever needed.
- ☐ Requires a school nurse or trained diabetes personnel to check blood glucose.
- ☐ Uses a smartphone or other monitoring technology to track blood glucose values.

Student's Self-Care CGM Skills	Independent?	
The student troubleshoots alarms and malfunctions.	Yes	No
The student knows what to do and is able to deal with a HIGH alarm.	Yes	No
The student knows what to do and is able to deal with a LOW alarm.	Yes	No
The student can calibrate the CGM.	Yes	No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	Yes	No

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

Other instructions for the school health team: _____
_____

Additional information for WSD Staff for Student(s) who have a CGM:

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood level. If the student has signs or symptoms of hypoglycemia, check fingertip glucose regardless of the CGM.
- Insulin injection should be given at least three inches away from 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 parent/guardian. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Hypoglycemia Treatment

Low Blood Glucose:

Words student may use to describe feeling with **low blood glucose**: _____
_____

- If exhibiting symptoms of hypoglycemia, or if blood glucose is less than _____mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.
- Re-check blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.
- Additional treatment: _____
  _____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- **Position student on his or her side to prevent choking**
- **Give Glucagon**: 1mg _____ 0.5mg _____ Other (dose): _____
- **Route**: Subcutaneous (SC) _____ Intramuscular (IM) _____
- **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.**

High Blood Glucose:

Words student may use to describe feeling of **high blood glucose:** _____

_____

- Check – **Urine** _____ or **Blood for Ketones** _____ every _____ hours when blood glucose levels are above _____mg/dL.
- For blood glucose greater than _____mg/dL & at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _____mg/dL.
- For insulin pump users see **(Additional Information for Student with Insulin Pump)**.
- Allow unrestricted access to bathroom.
- Give extra water and/or non-sugar containing drinks (no fruit juices): _____ ounces per hour.
- Follow physical activity and sports orders. (see **Physical Activity and Sports** section)

Additional Treatment for Ketones: _____

_____

If the student has symptoms of hyperglycemia emergency, call 911 and contact parent/guardian and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea/vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

Insulin Therapy

Insulin Delivery Device: ☐ Syringe ☐ Insulin Pen ☐ Insulin Pump

Carbohydrate Coverage/Correction Dose: _____

Carbohydrate Coverage Ratio: 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

Correction Dose Scale:

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
Blood glucose _____ to _____ mg/dL, give _____ units Blood glucose _____ to _____ mg/dL, give _____ units

When to Give Insulin:

Breakfast-
☐ Carbohydrate coverage only.
☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
☐ Other: _____

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.

☐ Correction dose only: For blood glucose greater than _____mg/dL
and at least __2__ hours since last insulin dose.

☐ Other: _____

Fixed Insulin Therapy or Pre-dose Insulin: 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: _____

Parental Authorization to Adjust Insulin Dose:

1. Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/-_____ units of insulin. ☐ Yes ☐ No *(Please be aware WSD only allows up to a 3 unit difference.)*

2. 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

3. Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/-_____ units of insulin. ☐ Yes ☐ No *(Please be aware that WSD only allows +1-3 units only.)*

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.

Insulin Pump Information:

Student has an Insulin Pump? ☐Yes ☐No
Brand/model of pump: _____
Type of insulin in pump: _____
Basal rates during school: Time: _____ Basal rate: _____ Time: _____ Basal rate: _____
Time: _____ Basal rate: _____ Time: _____ Basal rate: _____
(If needed, School Nurse is allowed to suspend, but not able to adjust basal rates at school.)

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.

Student's Self- Care Pump Skills	Independent?	
Counts Carbohydrates	Yes	No
Calculates correct amount of insulin for carbohydrates consumed.	Yes	No
Administers Correction Dose	Yes	No
Calculates and sets basal profiles.	Yes	No
Calculates and sets temporary basal rate.	Yes	No
Changes Batteries	Yes	No
Disconnects Pump	Yes	No
Reconnects pump to infusion set.	Yes	No
Prepares reservoir, pod, and/or tubing.	Yes	No
Inserts Infusion Set	Yes	No
Troubleshoots Alarms and Malfunctions	Yes	No
Give injection with syringe/pen if needed.	Yes	No

Other Diabetes Medications:

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

Meal Plan

Student's Self-Care Nutrition Skills:

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

Scheduled Snack Times: _____

Instructions for when food is provided to the class (i.e. class party, birthday treat)**:** _____
_____

Special Event / Party Food Permitted: ☐ At Parent/Guardian Discretion ☐ At Student Discretion

Physical Activity & Sports

May disconnect from pump for sports activities: ☐ Yes, for _____ hours ☐ No
Suspend pump use: ☐ Yes, for _____ hours ☐ No

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 of carbohydrate
- ☐ 30 grams of carbohydrate
- ☐ Other: _____

Before

- ☐ Every 30 minutes during
- ☐ Every 60 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. (See Administer Insulin for additional information for students on insulin pumps.)

Disaster Plan

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

- ☐ Continue to follow orders contained in this DMMP.
- ☐ Additional insulin orders as follows (e.g., dinner and nighttime): _____
  _____
  _____
- ☐ Other: _____

Signature/Agreement Section

This Diabetes Medical Management Plan has been approved by:

_____	_____	_____
Student's Physician/Health Care Provider Name	Signature	Date

I, (parent/guardian) _____, give permission to the School Nurse or another qualified healthcare 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 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 healthcare professional to contact my child's physician/health care provider. Acknowledged and received by:

_____
Student's Parent/Guardian Signature Date

_____
School Nurse/Other Qualified Health Care Personnel Signature Date