



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?	
	Yes	No
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?	
	Yes	No
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

DIABETES - Emergency Action Plan **School Year:** _____ **Picture**

Name: _____ **DOB:** _____ **School/Grade:** _____

Parent/Guardian: _____ **Phone(s):** _____

 **When Blood Glucose is in Target Range (or between _____ and _____)**
Student is fine

HYPOGLYCEMIA – When Blood Glucose is Below 80 (or below _____)
Causes: too much insulin; missing or delaying meals or snacks; not eating enough food; intense or unplanned physical activity; being ill.
Onset: sudden, symptoms may progress rapidly

 MILD OR MODERATE HYPOGLYCEMIA Please check previous symptoms			 SEVERE HYPOGLYCEMIA Please check previous symptoms		
Anxiety	Hunger	Shakiness	Combative	Inability to eat or drink	Unconscious
Behavior change	Headache	Slurred speech	Unresponsive	Seizures	Other:
Blurry Vision	Irritability	Sweating	Other:		
Confusion	Paleness	Weakness			
Crying	Personality change	Other:			
Dizziness	Poor concentration				
Drowsiness	Poor coordination				



ACTIONS FOR MILD OR MODERATE HYPOGLYCEMIA

1. Give student fast-acting sugar source
2. Wait 15 minutes.
3. Recheck blood glucose.
4. Repeat fast-acting sugar source if symptoms persist OR blood glucose is less than 80 or _____
5. Other:

ACTIONS FOR SEVERE HYPOGLYCEMIA

1. Don't attempt to give anything by mouth.
2. Position on side, if possible.
3. Contact trained diabetes personnel.
4. Administer glucagon, if prescribed.
5. **Call 911.** Stay with student until EMS arrives.
6. Contact parents/guardian.
7. Stay with student.
8. Other:

HYPERGLYCEMIA - When Blood Glucose is over 250 (or above _____)
Causes: too little insulin; too much food; insulin pump or infusion set malfunction; decreased physical activity; illness; infection; injury; severe physical or emotional stress.
Onset: over several hours or days.

 MILD OR MODERATE HYPERGLYCEMIA Please check previous symptoms		 SEVERE HYPERGLYCEMIA Please check previous symptoms	
Behavior Change	Headache	Blurred vision	Nausea/vomiting
Blurry Vision	Stomach pains	Breathing changes (Kussmaul breathing)	Severe abdominal pain
Fatigue/sleepiness	Thirst/dry mouth	Chest pain	Sweet, fruity breath
Frequent Urination	Other:	Decreased consciousness	Other:
		Increased hunger	

ACTIONS FOR MILD OR MODERATE HYPERGLYCEMIA

1. Allow liberal bathroom privileges.
2. Encourage student to drink water or sugar-free drinks.
3. Administer correction dose if on a pump.
4. Contact parent if blood sugar is over _____ mg/dl.
5. Other:

ACTIONS FOR SEVERE HYPERGLYCEMIA

- Administer correction dose of insulin if on a pump
- Call parent/guardian.
- Stay with student
- Call 911 if patient has breathing changes or decreased consciousness.
- Stay with student until EMS arrives
- Other:

INSULIN PUMP FAILURE (please indicate plan for insulin pump failure)
 NA/not on an insulin pump administer insulin via syringe/vial or pen School nurse can replace site (only if previously trained)
 student can replace site alone or with minimal assistance parent to come and replace site Other:

Never send a child with suspected low blood glucose anywhere alone!

SIGNATURES

I have read and approve of the above emergency action plan.

Parent: _____ **Date:** _____

School Nurse: _____ **Date:** _____

Copies of this EAP given to (check all that apply): Classroom Teacher(s) PE Teacher(s) Others _____

FAST ACTING SUGAR SOURCES (15 grams carbohydrates): 3-4 glucose tablets OR 4 ounces juice OR 0.9 ounce packet of fruit snacks