

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.

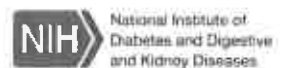
Date of plan: _____ This plan is valid for the current school year: _____ - _____

Student information

Student's name: _____ Date of birth: _____
Date of diabetes diagnosis: _____ Type 1 Type 2 Other: _____
School: _____ School phone number: _____
Grade: _____ Homeroom teacher: _____
School nurse: _____ 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: _____



Checking blood glucose

Brand/model of blood glucose meter: _____

Target range of blood glucose:

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

Check blood glucose level:

- Before breakfast After breakfast _____ Hours after breakfast 2 hours after a correction dose
 Before lunch After lunch _____ Hours after lunch Before dismissal
 Mid-morning Before PE After PE Other: _____
 As needed for signs/symptoms of low or high blood glucose As needed for signs/symptoms of illness

Preferred site of testing: Side of fingertip Other: _____

Note: The side of 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
 Requires school nurse or trained diabetes personnel to check blood glucose
 Uses a smartphone or other monitoring technology to track blood glucose values

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

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

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

Threshold suspend setting: _____

CGM may be used for insulin calculation if glucose is between ____-____ mg/dL Yes No

CGM may be used for hypoglycemia management Yes No

CGM may be used for hyperglycemia management Yes No

Additional information for student with 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.

Student's Self-care CGM Skills: Check "Yes" or "No" if the student can perform the skill independently.

The student troubleshoots alarms and malfunctions.	<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
The student knows what to do and is able to deal with a LOW alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student can calibrate the CGM.	<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

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

Other instructions for the school health team: _____



National Institute of
Diabetes and Digestive
and Kidney Diseases

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: _____

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

- Position the student on his or her side to prevent choking.
- Administer glucagon Name of glucagon used: _____

Injection:

- 1 mg ½ mg Other (dose) _____
- Route: Subcutaneous (SC) Intramuscular (IM)
- Site for glucagon injection: Buttocks Arm Thigh Other: _____

Nasal route:

- 3 mg
- Route: Intranasal (IN)
- Site: Nose

- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Contact the student's health care provider.
- If on insulin pump, stop by placing mode in suspend or disconnect. Always send pump with EMS to hospital.

Hyperglycemia treatment

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

- Check Urine Blood for ketones every _____ hours when blood glucose levels are above _____ mg/dL.
- For blood glucose greater than _____ mg/dL AND 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 the bathroom.
- 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. (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.



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

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

Carbohydrate Dose Calculation Example

Total Grams of Carbohydrate to Be Eaten + Insulin-to-Carbohydrate Ratio = _____ Units of Insulin

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

Correction Dose Calculation Example

(Current Blood Glucose – Target Blood Glucose) + Correction Factor = _____ 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

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

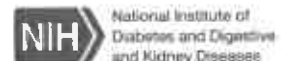
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- Other: _____

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 _____ 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: _____

Basal Insulin Therapy Name of insulin: _____

To be given during school hours: ___ Pre-breakfast dose: ___ units

___ Pre-lunch dose: ___ units

___ Pre-dinner dose: ___ units

Other diabetes medications:

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

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

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: _____

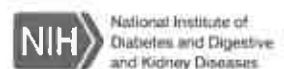
Basal rates during school: Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____

Other pump instructions: _____

Type of infusion set: _____



Additional Information for student with insulin pump (continued)

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

Student's Self-care Pump Skills: Check "Yes" or "No" if the student can perform the skill independently.

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

Meal plan

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

Other times to give snacks and content/amount: _____

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

Parent/guardian substitution of food for meals, snacks and special events/parties permitted.

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

Student's self-care nutrition skills:

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



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 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/emergency and drill plan

To prepare for an unplanned disaster, emergency (72 hours) or drill, obtain emergency supply kit from parents/guardians. School nurse or other designated personnel should take student's diabetes supplies and medications to student's destination to make available to student for the duration of the unplanned disaster, emergency, or drill.

Continue to follow orders contained in this DMMP.

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

Other: _____

Signatures

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider _____

Date _____

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.

Acknowledged and received by:

Student's Parent/Guardian _____

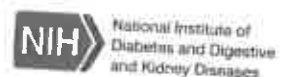
Date _____

Student's Parent/Guardian _____

Date _____

School Nurse/Other Qualified Health Care Personnel _____

Date _____



Diabetes Medical Management Plan

IDENTIFIERS

Student Information

Student's Name: _____ Date of birth: _____
 School: _____ Grade: _____ Homeroom teacher: _____

Clinical Provider Information

School Nurse: _____
 Endocrinologist: _____ Phone: _____



Designated Staff

Designated staff to provide support with diabetes care (minimum 2):

1. _____
2. _____
3. _____

CONTACTS

	Name	Relationship	Preferred phone #	Alternate phone #
1st				
2nd				
3rd				

GENERAL

School Day

Before-school care: No Yes _____ After-school care: No Yes _____
 School bus #: a.m. _____ p.m. _____ Emergency Release School Bus Parent Pick Up

Plans

Individual Health Plan Emergency Action Plan 504 Plan IEP

Level of Management

Dependent Developing Self-Management Skills Self-Manager

SCHOOL must ensure a kit is accessible at all times (class, gym, field trips, lockdowns, fire drills, etc.).
 Advise parents when running low on supplies. **PARENT** must maintain/refresh supplies.

EMERGENCY KITS / SUPPLIES

CONTENTS (check all that apply)	With student	Classroom	Office	Other location(s)
Blood glucose meter, test strips, lancets				
Fast-acting glucose				
Carbohydrate snack(s)				
Glucagon (expiry date: ___/___)				
Sharps disposal container				
Ketone strips/meter				
Insulin pen, pen needles, insulin (in case of pump failure)				
Extra batteries for meter				
Other:				

Checking Blood Glucose

Target Blood Glucose range: _____ to _____

 Capillary Blood Glucose Checking

- Before breakfast Before Lunch Scheduled: _____
 Before PE Before Recess When symptoms do not match CGM reading
 2 Hours after correction dose Before bus ride
 As needed for high/low Other: _____

Preferred site of testing: _____

Student's self-care blood glucose checking skills:

- Independently checks own blood glucose
 May check blood glucose with supervision
 Requires school nurse or trained diabetes personnel to check blood glucose
 Uses a smartphone or other monitoring technology to track blood glucose value

Continuous Glucose Monitor Yes No Brand/Model: _____ Alarms set for Severe low: _____ low: _____ high: _____

Predictive alarm: _____

Threshold for suspend setting (if applicable): _____

 CGM may be used for Insulin calculations if glucose is between _____ and _____ CGM may be used for hypoglycemia management CGM may be used for hyperglycemia management Student is able to troubleshoot alarms and malfunctions Student is able to calibrate CGM Student is able to manage HIGH alarm Student is able to manage LOW alarm**Procedures:**

-
- Refer to
- Procedure for CBG Testing*

General Nutrition

- Student can eat snack and lunch at regular school times
 Student has scheduled snack times
 - Before PE
 - Before Recess
 - Before dismissal

Meals

- Student eats school provided breakfast lunch
 Student brings meals from home

Counting Carbohydrates

- Student requires assistance counting carbohydrates
 Student requires supervision counting carbohydrates
 Student can count carbohydrates independently

Procedures:

-
- Refer to
- Procedure for Counting Carbohydrates*

Insulin Management

Insulin dosage is ordered for:

- Lunchtime
- When BG is greater than _____ mg/dL (if it has been more than 3 hours since last dose)
- When student has ketones present
- Other

Form of Insulin Administration

- Vial/syringe Pen Pump Model: _____

Insulin Management

- Not independent. Student needs complete assistance with insulin administration.
 - Caregiver to draw up, check dose with another trained caregiver, and administer insulin.
- Partially independent. Student needs assistance from caregiver with drawing up and checking insulin dose but administers injection independently.
 - Student will draw up or dial appropriate dose of insulin.
 - Caregiver will verify number of units in syringe or insulin pen and check dose with another trained caregiver.
- Completely independent. Student requires no assistance from caregiver with drawing and administering injection.

Procedures

- Refer to *Procedure for Injectable Insulin Administration*
- Refer to *Procedure for Insulin Pen Administration*
- Refer to *Procedure for Insulin Pump*

The student may use these words to describe a high blood sugar:

Usual symptoms of high blood sugar for this student are:

- | | | |
|---|---|---|
| <input type="checkbox"/> Extreme thirst | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hunger | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Warm, flushed skin | <input type="checkbox"/> Irritability | <input type="checkbox"/> Other: _____ |

Usual symptoms of SEVERE high blood sugar

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Rapid, shallow breathing | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Fruity-smelling breath |
|---|-----------------------------------|---|

Level of Care

- Student needs assistance with high blood glucose management
- Student requires supervision with high blood glucose management
- Student manages high blood glucose independently

Procedures

- Refer to *Procedure for high or low blood glucose*

Checking for Ketones

- This student does not check for ketones at school
 - If BG is above _____, check ketones using
- Student uses urine sticks ketone blood meter

Level of Care

- Student requires assistance checking ketones
- Student requires supervision checking ketones
- Student checks ketones independently

Procedures

- Refer to *Procedure checking ketones*

SYMPTOMS

MILD-TO-MODERATE LOW BLOOD SUGAR

When blood sugar (BG) is low, the student may have these symptoms:

- | | | |
|------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Shakiness | <input type="checkbox"/> Irritable/grouchy | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hunger | <input type="checkbox"/> Weakness/fatigue | <input type="checkbox"/> Paleness |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Other(s) _____ | |

The student may also use these words to describe feeling low:

Do not leave student with low blood glucose unattended.
Treat the low blood sugar IMMEDIATELY.
Remain with student.

First, check blood sugar (BG). Even students who do their own checks may need help when their blood sugar is low. Then follow these steps:

CHECK

- If BG is under _____ OR
- If symptoms of hypoglycemia are present

TREAT

- Immediately give _____ grams of fast-acting sugar (See below for student preferences and amounts)

REPEAT

- After 15 minutes, check BG again:
- If still under _____ treat again as above.
- Repeat cycle every 10 to 15 minutes until BG is above _____

When BG is over _____:

- If meal or snack is more than 1 hour away, give long lasting carbohydrate snack
- If meals or snack less than 1 hour away, no action needed. Student can eat at regular time

How much fast-acting sugar to give

✓		10 g	15 g
	Glucose tablets (4 g each)	2 tabs (8 g)	4 tabs (16 g)
	Juice or regular soft drink	½ cup	¾ cup
	Skittles	10 pieces	15 pieces
	Rockets (roll candy)	1 roll (7 g)	2 rolls (14 g)
	Table sugar	2 tsp / 2 pkgs	1 Tbsp / 3 pkgs

ACTION

SEVERE HYPOGLYCEMIA

Symptoms

- Unresponsive or unconscious
- Having a seizure
- So uncooperative that you can't give juice or sugar by mouth

What to do

1. Place the student in recovery position.
2. Have someone call 911. Then call parents.
3. Stay with the student until ambulance arrives. Do not give food or drink (choking hazard).
4. Give Glucagon, if ordered.

- Yes, give glucagon**
- No, do not give glucagon**

Procedures

- Refer to *Procedure for Injectable Glucagon Administration*
- Refer to *Procedure for Intranasal Glucagon Administration*

Authorization for:

- Hospital transport
- Emergency glucagon administration
- Insulin Calculations
- Insulin Administration
- Blood Glucose Monitoring
- Ketone Checking
- Carbohydrate counting
- Communication to provider

Parent/guardian signature: _____ Date: _____

Parent/guardian name (print): _____ Relationship: _____

Student signature: _____

Nurse's signature: _____ Date: _____

Nurse's name (print): _____