

Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. Be sure to check any boxes deemed appropriate.

This DMMP should be renewed every year or if changes to the care plan occur.

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: _____

Contact information

Student's physician/health care provider: _____

Address: _____

Telephone: _____ Emergency number: _____

Email address: _____

Parent/guardian 1: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Parent/guardian 2: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

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

Student's self-care blood glucose checking skills:

- Independently checks own blood glucose
- May check blood glucose with supervision
- Requires a 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 (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

Student's self-care CGM skills	Independent?	
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: _____

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 and :

- Administer glucagon; Name of glucagon used: _____

Nasal route: 3 mg or

Injection: 1 mg ½ mg Other (dose) _____

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

- 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.

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	= _____	Units of Insulin
Insulin-to-Carbohydrate Ratio		

Correction Dose: Blood glucose correction factor (insulin sensitivity factor) = _____

Target blood glucose = _____ mg/dL

Correction Dose Calculation Example

Current Blood Glucose - Target Blood Glucose	= _____	Units of Insulin
Correction Factor		

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/self administer insulin:

Breakfast

- Carbohydrate coverage only Carbohydrate coverage plus correction dose Correction dose only

Lunch

- Carbohydrate coverage only Carbohydrate coverage plus correction Correction dose only

Snack

- No coverage for snack Carbohydrate coverage only Correction dose only
 Carbohydrate coverage plus correction dose

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/taken 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: _____

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: _____

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

Additional information for student with insulin pump (continued)

Student's self-care pump skills	Independent?	
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/Snack	Time	Carbohydrate Content (grams)
Breakfast		_____ to _____
Mid-morning snack		_____ to _____
Lunch		_____ to _____
Mid-afternoon snack		_____ to _____

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 Student can self manage or designated personnel must manage by following physical activity guidelines as listed below:

A quick-acting source of glucose such as glucose tabs and/or sugar-containing juice must be available

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

(See **Administer Insulin** for additional information for students on insulin pumps.)

Supplies

An emergency supply kit provided by the parents/guardians will be supplied to the school and includes:

- glucagon insulin extra pump supplies extra continuous glucose monitoring
- extra testing supplies extra medication administration supplies.

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 designated personnel of St. Rita high 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 if needed.

Acknowledged and received by:

Student's Parent/Guardian Signature

Date

This form was modified from the American Diabetes Association diabetes management form (October 2019).