Diabetes Medical Management Plan (DMMP)

Student Picture

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 and other authorized personnel.

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

Student Information

Student's Name _____ Date of Birth _____ ID # _____

Date of diabetes diagnosis: _____ ☐ Type 1 ☐ Type 2 ☐ Other: _____

School: _____ School phone number: _____

Grade: _____ Homeroom teacher: _____

School Nurse: _____ Phone number: _____

☐ 504 ☐ IEP

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: _____

Hypoglycemia Treatment

Does student recognize/feel their symptoms of hypoglycemia? ☐ Yes ☐ No

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

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose levels 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: _____

_____

Symptoms of hypoglycemia include:

- Headache
- Sweating, shakiness
- Pale, dizziness
- Tired, falling asleep in class
- Mood changes
- Anxiety, irritability
- Blurred vision
- Slurred speech
- Hungry
- Inability to concentrate
- Poor coordination

Emergency Hypoglycemia Treatment:

If the student is unable to swallow, is unconscious or unresponsive, or is having seizure activity.

- Position the student on his or her side to prevent chocking
- Give glucagon: ☐ 1 mg ☐ ½ mg ☐ Other: (Dose) _____
  - Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
  - Site for glucagon injection: ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other _____
- Call 911 (emergency Medical Services)
- If insulin pump is in use, place pump in suspend/stop mode or disconnect at insertion site
- Contact a Parent/Guardian
- Remain with the student until help arrives

Hyperglycemia Treatment

Does student recognize/feel their symptoms of hyperglycemia? ☐ Yes ☐ No

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** section.
- 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 orders (**See Physical Activity** section) (page 5)

Symptoms of hyperglycemia include:

- Dry mouth
- Extreme thirst
- Nausea and vomiting
- Severe abdominal pain
- Heavy breathing or shortness of breath
- Chest pain
- Increasing sleepiness or lethargy
- Depressed level of consciousness
- Frequent urge to urinate
- Fruity breath

Checking Blood Glucose

Brand/model of blood glucose meter: _____

Target range of blood glucose: _____

Check blood glucose level:

- ☐ Breakfast
- ☐ Lunch
- ☐ As Needed
- ☐ Before PE
- ☐ Before Snack
- ☐ Before dismissal
- ☐ Other _____

Student's self-care blood glucose checking skills:

- ☐ Independently checks own blood glucose
- ☐ May check blood glucose with supervision
- ☐ Requires a school nurse to check blood glucose
- ☐ Uses a smartphone or other monitoring technology to track blood glucose values

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

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

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

Threshold suspend setting: _____

Additional Information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level. ☐ Yes ☐ No
- If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of CGM. ☐ Yes ☐ No
- 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	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: _____

_____

_____

Insulin Therapy

Insulin delivery device: ☐ Syringe ☐ Insulin Pen ☐ Insulin pump

Insulin Therapy Name of Insulin: _____

☐ _____ Units of insulin given pre-breakfast daily ☐ _____ Units of insulin given per_____ grams of carbs

☐ _____ Units of insulin given pre-lunch daily

☐ _____ Units of insulin given pre-snack daily

☐ Other _____

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

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

Parents/Guardians Authorization to Adjust Insulin Dose

☐ Yes ☐ No Parents/Guardians are authorized to increase or decrease insulin therapy.

☐ Other _____

Student's self-care insulin administration skills:

☐ Independently calculates and gives own injections.

☐ May calculate/give own injections with supervision

☐ Requires school nurse to calculate dose and student can give own injection with supervision

☐ Requires school nurse 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: _____

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	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rates	☐ 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

Other diabetes medications

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

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

Meals/Snacks

Meal/snack	Time
Breakfast	
Mid-morning snack	
Lunch	
Mid-afternoon snack	

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

_____

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 to count carbohydrates

Physical activity

Activity Restrictions ☐ None ☐ Other _____

Student should eat _____ grams of carbohydrates if blood glucose level is _____ prior to physical activity.

☐ Other_____

Avoid physical activity when blood glucose is greater than _____mg/dl or if urine/blood ketones are moderate to large.

(See **Additional information for students with insulin pump** (page 4))

Avoid physical activity when blood glucose is lower than _____ mg/dl.

Disaster Plan/Shelter in Place

To prepare for an unplanned disaster or emergency (72 hours), obtain an 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: _____

_____

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 to perform and carry out the diabetes care tasks as outlined in (student's name) _____ Diabetes Medical Management Plan. I also consent to the release of the information contained in the 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 main my child's health and safety. I also give permission to the school nurse to contact my child's physician/health care provider. I acknowledge that I am responsible for supplying all diabetic equipment, supplies, medication, snacks, etc. needed to carry out the DMMP.

Acknowledged and received by:

_____ _____

Student's Parent/Guardian *Date*

_____ _____

Student's Parent/Guardian *Date*

_____ _____

School Nurse *Date*

References: Tools for Effective Diabetes Management, National Diabetes Education Program
IEMSC Guidelines for the Nurse in the School Setting, 2010