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 a 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: _____

Additional information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level. If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the 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	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: _____

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.
- 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) and the student's parents/guardians.
- Contact the student's health care provider.

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

Insulin therapy (continued)

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
$\frac{\textit{Total Grams of Carbohydrate to Be Eaten}}{\textit{Insulin-to-Carbohydrate Ratio}} = \_\_\_\_ \textit{ Units of Insulin}$

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

Correction Dose Calculation Example
$\frac{\textit{Current Blood Glucose – Target Blood Glucose}}{\textit{Correction Factor}} = \_\_\_\_ \textit{ Units of Insulin}$

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: _____

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: _____

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 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

Other diabetes medications

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

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

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): _____

_____

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 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: _____

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

Maryland State Management of Diabetes at School/Order Form

This order is valid only for the Current School Year: _____(including summer session)

Student: _____ **DOB:** _____

School: _____ **Grade:** _____

CONTACT INFORMATION

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____

Other Emergency Contact: _____

Insulin Orders (complete only if insulin is needed at school):

1. Insulin administration via:

☐ Syringe and vial ☐ Insulin pen ☐ Insulin pump ☐ Other _____

☐ Insulin pump Type of pump: _____ Basal rates: _____

2. Insulin Before Lunch/Meals: Name of Insulin: _____

☐ Routine lunchtime dose: _____

☐ Per sliding scale as follows:

Meals

Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units

☐ Calculated insulin dose (**add** carbohydrate coverage and correction dose for total insulin dose):
Carbohydrate Coverage: Insulin to carbohydrate ratio
Give _____ # unit(s) insulin per_____gms carbohydrate.
Correction:
Give _____ # unit(s) insulin per_____ mg/dl of glucose **above** _____ mg/dl
Subtract _____ # units for every _____ mg/dl of glucose **below** _____mg/dl

☐ Insulin may be given after lunch if _____

3. Other times insulin may be given:

☐ Snack: Dose: _____ ☐ Calculated as above.

☐ Ketones: If ketones are _____ Give/Add: _____unit(s)

If ketones are _____ Give/Add: _____unit(s)

☐ Snack:

Blood Glucose Give:

_____ units

_____ units

_____ units

Health Care Provider Authorization for Management of Diabetes in School

My signature below provides authorization for the above written orders. This authorization is for a maximum of one school year. If changes are indicated, I will provide new written authorization, which may be faxed.

Health Care Provider Name: _____ **Signature:** _____ (original or stamped signature) ***Sign both sides.**

Address: _____ **City:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Date:** _____

Use for Prescriber's Address Stamp

Parent Consent for Management of Diabetes at School

I (We) request designated school personnel to administer the medication and treatment orders as prescribed above. I agree

1. To provide the necessary supplies and equipment
2. To notify the school nurse if there is a change in the student's diabetes management or health care provider.

I authorize the school nurse to communicate with the health care provider as necessary.

Parent/Guardian Signature _____ Date _____ ***Sign both sides.**

_____ Date _____

Order reviewed and signed by School Nurse (per local policy): Date:

Maryland State Management of Diabetes at School/Order Form

Student: _____

Blood Glucose Monitoring:

Target range for blood glucose monitoring at school: _____

- ☐ Before snacks ☐ 2 hours or _____ hours after lunch
- ☐ Before meals ☐ 2 hours or _____ hours after a correction dose
- ☐ As needed for symptoms of hypo/hyperglycemia
- ☐ With signs and symptoms of illness
- ☐ Other times: _____

Hypoglycemia – blood glucose less than _____

- ☐ Self treatment for mild lows.
- ☐ Give _____ grams of fast-acting carbohydrate according to care plan. Recheck BG in 10-15 mins. Repeat treatment if BG less than ___mg/dl
- ☐ Provide extra protein & carbohydrate snack after treating low if next meal/snack greater than ____ minutes away
- ☐ Suspend pump for severe hypoglycemia for _____ mins.

If student is unconscious, having a seizure or unable to swallow, presume student is having a low blood sugar and:
Call 911, notify parent
- ☐ **Glucagon injection (1 mg in 1 cc) _____ mg, subcutaneously or intramuscular (IM)**
- ☐ **OK to use glucose gel inside cheek, even if unconscious, seizing.**
- ☐ **Other:** _____

Hyperglycemia – blood glucose greater than _____

- ☐ Check urine ketones, follow care plan, administer insulin as per orders. ☐ For pumps, insulin may be given by syringe or pen if needed.
- ☐ Encourage sugar free fluids, at least _____ ounces per _____.
- ☐ If student complains of nausea, vomiting or abdominal pain; check urine ketones & check insulin administration orders.
- ☐ Other: _____

* Transport to local Emergency Room may be needed with vomiting and large ketones.

Meal Plan

- ☐ AM snack, time: _____ ☐ PM snack time: _____ ☐ Avoid snack if blood glucose greater than _____ mg/dl.
- ☐ Lunch: _____
- ☐ Extra food allowed; ☐ Parent's discretion; ☐ Student's discretion

Exercise (check and/or complete all that apply)

Fast-acting carbohydrate source must be available before, during and after all exercise.

- ☐ With student ☐ With teacher

If most recent blood glucose is less than _____, exercise can occur when blood glucose is corrected and above _____.

- ☐ Eat _____ grams of carbohydrate ☐ Before ☐ Every 30 mins during ☐ After vigorous exercise
- ☐ Avoid exercise when blood glucose is greater than _____ or ketones are _____

Bus Transportation

- ☐ Blood glucose monitoring not required prior to boarding bus
- ☐ Check blood glucose 15 minutes prior to boarding bus
- ☐ Allow student to eat on bus if having symptoms of low blood glucose
- ☐ Provide care as follows: _____

Health Care Provider Assessment

Student can self-perform the following procedures (school nurse and parent must verify competency):

- ☐ Blood glucose monitoring ☐ Measuring insulin ☐ Injecting insulin ☐ Determining insulin dose
- ☐ Independently operating insulin pump
- ☐ Other: _____

Disaster Plan (if needed for lockdown, 24 hr shelter in place):

- ☐ Follow insulin orders as on Management Form
- ☐ Additional insulin orders as follows: _____
- ☐ Administer long acting insulin as follows: _____
- ☐ Other: _____

Other instructions:

_____

Health Care Providers Signature: _____ Phone: _____ Date: _____

Parent's Signature: _____ Phone: _____ Date: _____

Order reviewed by School Nurse (per local policy): _____ Date: _____

Maryland State Supplemental Form for Students with Insulin Pumps
This order is valid only for the Current School Year:_____ (including summer session)

Student: _____ **DOB:** _____
School: _____ **Grade:** _____

CONTACT INFORMATION:

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____
Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____
Pump Resource Person: _____ Phone: _____
Other Emergency Contact: _____

Pump Management

Type of pump: _____ Start Date for Pump Therapy: _____
Type of Insulin in pump: _____

Basal rates: _____ 12am to _____ Comment: _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Insulin/carbohydrate ratio: _____ Check Management of Diabetes at School Order or correction factor
Hyperglycemia:
____ Pump site should be changed if BG greater than _____ times _____
____ Insulin should be given by syringe or pen if needed _____

Management Skills of Student

- As verified by school nurse, health care provider and parent

		Independent?
Count carbohydrates	__ yes	__ no
Calculate an insulin dose	__ yes	__ no
Bolus an insulin dose	__ yes	__ no
Reset basal rate profiles	__ yes	__ no
Set a temporary basal rate	__ yes	__ no
Disconnect pump	__ yes	__ no
Reconnect pump at infusion set	__ yes	__ no
Prepare infusion set for insertion	__ yes	__ no
Insert infusion set	__ yes	__ no
Troubleshoot alarms and malfunctions	__yes	__ no
Give self injection if needed	__ yes	__ no
Change batteries	__ yes	__ no

__ Student is non-independent Child Lock On? Yes No

Pump Supplies

Extra supplies needed include: Infusion sets, reservoir/cartridges, insertion device, insulin vial & syringes, batteries
Location of supplies: _____

Disaster Plan (If needed for lockdown, etc):

☐ Follow Insulin orders as on Management Form
☐ Insulin doses as follows: _____
Other: _____

Health Care Provider's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

Order reviewed by School Nurse (per local policy): **Date:** _____