

# 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 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

## 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	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):

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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:

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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):

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- 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

$\frac{\text{Total Grams of Carbohydrate to Be Eaten}}{\text{Insulin-to-Carbohydrate Ratio}}$	=	_____ Units of Insulin
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**Correction Dose:** Blood glucose correction factor (insulin sensitivity factor) = \_\_\_\_\_

Target blood glucose = \_\_\_\_\_ mg/dL

#### Correction Dose Calculation Example

$\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Correction Factor}}$	=	_____ Units of Insulin
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**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.

## Insulin therapy (continued)

### 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: \_\_\_\_\_

### 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:

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parents/guardians authorization should be obtained before administering a correction dose.  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> 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. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> 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.

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### 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: | <input type="checkbox"/> Yes, for _____ hours                        | <input type="checkbox"/> No |
| Set a temporary basal rate:                     | <input type="checkbox"/> Yes, _____% temporary basal for _____ hours | <input type="checkbox"/> No |
| Suspend pump use:                               | <input type="checkbox"/> Yes, for _____ hours                        | <input type="checkbox"/> 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 _____

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):

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☐ Other: \_\_\_\_\_

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## 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

This form was developed by the American Diabetes Association.

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