## **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 informatio	n		
Student's name:		Date of birth:	
		pe 1 🔲 Type 2 🔲 Other:	
School:		School phone number:	
Grade:	Homeroom teacher:		
School nurse:		Phone:	
Contact informatio	n		
Parent/guardian 1:			
		Cell:	
Email address:			
Parent/guardian 2:			
		Cell:	
Email address:			
Student's physician/health	care provider:		
		ency number:	
Other emergency contacts:			
Name:	Relat	ionship:	
Telephone: Home:	Work:	Call·	

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 do:	se		
☐ Before lunch ☐ After lunch ☐ ☐ Hours after lunch ☐ Before d	lismissal			
☐ Mid-morning   ☐ Before PE   ☐ After PE   ☐ Other: _				
As needed for signs/symptoms of low or high blood glucose	ed for signs/symptor	ms of illness		
<b>Preferred site of testing:</b> ☐ Side of fingertip ☐ Other: Note: The side of the fingertip should always be used to check blood glucose level if hypogly	vcemia 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				
$\hfill \Box$ 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: Lov	v:	ligh:		
Threshold suspend setting:				
Additional information for student with CGM				
<ul> <li>Confirm CGM results with a blood glucose meter check before taking action on the</li> </ul>	sensor blood glucos	e level.		
If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.				
<ul> <li>Insulin injections should be given at least three inches away from the CGM insertion site.</li> </ul>				
<ul> <li>Do not disconnect from the CGM for sports activities.</li> <li>If the adhesive is peeling, reinforce it with approved medical tape.</li> </ul>				
<ul> <li>If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.</li> </ul>				
Refer to the manufacturer's instructions on how to use the student's device.				
Student's Self-care CGM Skills	Indepe	ndent?		
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.				
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.				
The student should be escorted to the nurse if the CGM alarm goes off: Yes No				
Other instructions for the school health team:				

Page 2 of 7, DMMP

Hypoglycemia treatment					
Student's usual symptoms of hypogl	ycemia (list below):				
If exhibiting symptoms of hypoglycemic product equal to grams of carb Recheck blood glucose in 15 minutes a Additional treatment:	ohydrate. nd repeat treatment if blood gluc	ose level is less than			
If the student is unable to eat or drin (jerking movement):	k, is unconscious or unrespons	ive, or is having seizure ac	tivity or convulsions		
<ul> <li>Position the student on his or her s</li> <li>Give glucagon: <ul> <li>Route:</li> <li>Site for glucagon injection:</li> </ul> </li> <li>Call 911 (Emergency Medical Service)</li> <li>Contact the student's health care p</li> </ul>	☐ 1 mg ☐ ½ mg ☐ Subcutaneous (SC) ☐ Buttocks ☐ Arm  ces) and the student's parents/gua	☐ Intramuscular (IM) ☐ Thigh ☐ Other			
Hyperglycemia treatmen Student's usual symptoms of hyperg					
<ul> <li>Check Urine Blood for k</li> <li>For blood glucose greater than insulin (see correction dose orders)</li> <li>Notify parents/guardians if blood g</li> <li>For insulin pump users: see Additional Allow unrestricted access to the base</li> <li>Give extra water and/or non-sugar-</li> </ul>	mg/dL AND at least ho ). glucose is over mg/dL. onal Information for Student with I athroom.	ours since last insulin dose, g	•		
Additional treatment for ketones:					
• Follow physical activity and sports	orders. (See <b>Physical Activity and</b>	d Sports)			
If the student has symptoms of a hyperoparents/guardians and health care provinces and vomiting, severe abdomina or lethargy, or depressed level of consci	ider. Symptoms of a hyperglycem I pain, heavy breathing or shortne	nia emergency include: dry r	nouth, extreme thirst,		
Insulin therapy					
Insulin delivery device:  Type of insulin therapy at school:	☐ Syringe ☐ Adjustable (basal-bolus) insulin	☐ Insulin pen☐ Fixed insulin therapy	☐ Insulin pump☐ No insulin		

Page 3 of 7, DMMP

Insulin thera	<b>py</b> (continu	ued)							
Adjustable (Basal-	-bolus) Insul	in Therapy							
<ul><li>Carbohydrate</li></ul>	Coverage/C	Correction Dose:	Name of i	insulin:					
<ul> <li>Carbohydrate</li> </ul>	_			_		<i>c.</i> 1.			
	arbohydrate							_	carbohydrate
Breakfast: 1	unit of insulin	per gram	s of carbohyo	drate <b>S</b>	<b>nack:</b> 1 unit	of insulir	n per	grams of	carbohydrate
		Carboh	ydrate Dose	e Calculat	tion Examp	ole			
	То	tal Grams of Carl	bohydrate to	o Be Eate	<u>n</u> = <i>U</i> !	nits of In	sulin		
		Insulin-to-Car							
Correction dose:	Blood gluco	se correction facto	or (insulin sen	nsitivity fac	.tor) =	Targ	et blood g	lucose =	mg/dL
		Correc	ction Dose (	Calculatio	on Example	2			
	Curr	ent Blood Glucos	e – Target Bl	lood Glud	ose =	Units of	Insulin		
			tion Factor						
Correction dose so	<b>cale</b> (use inst	ead of calculation	above to de	etermine i	nsulin corre	ction do:	se):		
Blood glucose	to	_ mg/dL, give	units	Blood g	lucose	to	mg/d	dL, give	units
Blood glucose	to	_ mg/dL, give	units	Blood g	lucose	to	mg/c	dL, give	units
See the worksheet of for instructions on h			_		-				
When to give insu	ılin:								
Breakfast									
Carbohydrate co	overage only								
Carbohydrate co	overage plus	correction dose w	vhen blood g	glucose is	greater tha	n	_ mg/dL ar	nd hou	ırs since last
Other:									
Lunch —									
Carbohydrate co									
Carbohydrate co	overage plus	correction dose w	vhen blood g	glucose is	greater tha	n	_ mg/dL ar	าd hoเ	ırs since last
Other:									
Snack									
☐ No coverage for	rsnack								
Carbohydrate co									
Carbohydrate co	,	correction dose w	vhen blood g	glucose is	greater tha	n	_ mg/dL ar	nd hou	urs since last
Correction dose	only: For blo	od glucose greate	er than	mg/dl	_ AND at lea	nst h	nours since	e last insulin	dose.
Other:									



Insulin the	erapy (continued)						
Fixed Insulin Th	herapy Name of insuli	n:					
Unit	s of insulin given pre-bre	eakfast daily					
Unit	s of insulin given pre-lur	nch daily					
Unit	s of insulin given pre-sna	ack daily					
Other:							
Parents/Guard	ians Authorization to	Adjust Insulin Dose					
Yes No	Parents/guardians aut	horization should be ob	tained before admir	nistering a correction	dose.		
Yes No	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 of	or decrease insulin-to	o-carbohydrate ratio	within the following		
	range: units p	er prescribed grams of c	arbohydrate, +/	grams of carbo	hydrate.		
Yes No	Parents/guardians are +/ units of ir	authorized to increase c nsulin.	or decrease fixed insi	ulin dose within the f	ollowing range:		
Student's self-o	care insulin administra	tion skills:					
☐ Independen	tly calculates and gives o	own injections.					
May calculate	e/give own injections w	ith supervision.					
Requires sch	ool nurse or trained dial	petes personnel to calcu	late dose and stude	nt can give own injec	tion with supervision.		
Requires sch	ool nurse or trained dial	petes personnel to calcu	late dose and give tl	ne injection.			
Additional	l information fo	r student with i	nsulin pump				
Brand/model o	of pump:		Type of insulin in pu	mp:			
Basal rates duri	ing school: Time:	Basal rate:	Time:	Basal rate:			
	Time:	Basal rate:	Time:	Basal rate:			
	Time:	Basal rate:					
Other pump in	structions:						
Type of infusion	n set:						
Appropriate in	fusion site(s):						
	ucose greater than usion site failure. Notify p	mg/dL that has not concepts and concepts are mg/dL that has not concepts are mg/dL that not concepts are mg/dL that not con	lecreased within	hours after correct	ion, consider pump		
		fusion set and/or replace	e reservoir, or give in	sulin by syringe or pe	en.		
		d or remove pump and c	_				
Physical Activit			, , ,	·			
•	from pump for sports a	ctivities: Yes, fo	r hours		□No		
Set a temporary							
sec a temporary	basal rate:	☐ Yes,	% temporary bas	sal for hours	□ No		

Page 5 of 7, DMMP

## 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	
Name:					
Meal plan					
Meal plan  Meal/Snack	Tim	e	Carbohydrate C	Content (grams)	
-	Tim	ie	<u> </u>	Content (grams)	
Meal/Snack			t		
Meal/Snack Breakfast	Tim		t	0	
Breakfast Mid-morning snack			tı	0	
Meal/Snack Breakfast Mid-morning snack Lunch			tı	o o	
Meal/Snack  Breakfast  Mid-morning snack  Lunch  Mid-afternoon snack	t/amount:		tı	0 0	
Meal/Snack  Breakfast  Mid-morning snack  Lunch  Mid-afternoon snack  Other times to give snacks and content	t/amount:	ort of a class party or	tı	0 0 0	
Meal/Snack  Breakfast  Mid-morning snack  Lunch  Mid-afternoon snack  Other times to give snacks and content  Instructions for when food is provided	t/amount: to the class (e.g., as pa	ort of a class party or	ti ti ti	0 0 0	
Meal/Snack  Breakfast  Mid-morning snack  Lunch  Mid-afternoon snack  Other times to give snacks and content  Instructions for when food is provided  Special event/party food permitted:	t/amount: to the class (e.g., as pa	ort of a class party or	ti ti ti	0 0 0	
Meal/Snack  Breakfast  Mid-morning snack  Lunch  Mid-afternoon snack  Other times to give snacks and content  Instructions for when food is provided  Special event/party food permitted:  Student's self-care nutrition skills:	to the class (e.g., as pa	ort of a class party or	ti ti ti	0 0	

Physical activity and sports	
A quick-acting source of glucose such as glucose tabs and/or sugar-containing juice of physical education activities and sports.	must be available at the site
Student should eat 15 grams 30 grams of carbohydrate other:	
☐ before ☐ every 30 minutes during ☐ every 60 minutes during ☐ after vigorous physica	l activity
If most recent blood glucose is less than mg/dL, student can participate in physical activ corrected and above mg/dL.	ity when blood glucose is
Avoid physical activity when blood glucose is greater than mg/dL or if urine/blood ketor	nes are moderate to large.
(See <b>Administer Insulin</b> 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	n 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 scho	
health care professional or trained diabetes personnel of (school)	
and carry out the diabetes care tasks as outlined in (student) Management Plan. I also consent to the release of the information contained in this Diabetes Me	
to all school staff members and other adults who have responsibility for my child and who may r	•
to maintain my child's health and safety. I also give permission to the school nurse or another qu	
to contact my child's physician/health care provider.	
Acknowledged and received by:	
Student's Parent/Guardian	Data
Student's raient/ Gualulan	Date
Student's Parent/Guardian	Date
School Nurse/Other Qualified Health Care Personnel	Date

Page 7 of 7, DMMP