National Diabetes Education Program
NDEP

American Diabetes Association®

Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardian. 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'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

Mother/Guardian: ____

Address: ____

Telephone: Home ______________ Work _______________ Cell: _____________________

Email Address: ____

Father/Guardian: ____

Address: ____

Telephone: Home ______________ Work _______________ Cell: ____________________

Email Address: ____

Student's Physician/Health Care Provider: ____

Address: ____

Telephone: ____

Email Address: ____________________ Emergency Number: _________________________

Other Emergency Contacts:

Name: ____________________________ Relationship:_______________________________

Telephone: Home __________________ Work ________________ Cell:_______________

CHECKING BLOOD GLUCOSE

Target range of blood glucose: ☐ 70-130 mg/dL ☐ 70-180 mg/dL

☐ Other: ______________________________

Check blood glucose level: ☐ Before lunch ☐ ________Hours after lunch

☐ 2 hours after a correction dose ☐ Mid-morning ☐ Before PE ☐ After PE

☐ Before dismissal ☐ Other: ______________________________

☐ As needed for signs/symptoms of low or high blood glucose

☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Fingertip ☐ Forearm ☐ Thigh ☐ Other: _________

Brand/Model of blood glucose meter: ______________________________

Note: 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 school nurse or trained diabetes personnel to check blood glucose

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No

Brand/Model: ______________________ Alarms set for: ☐(low) and ☐(high)

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

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 10-15 minutes and repeat treatment if blood glucose level is less than________mg/dL.

Additional treatment: ______________________________

HYPOGLYCEMIA TREATMENT (Continued)

Follow physical activity and sports orders (see page 7).

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
- Glucagon: ☐ 1 mg ☐ 1/2 mg Route: ☐ SC ☐ IM
- Site for glucagon injection: ☐ arm ☐ thigh ☐ Other: ____________________
- Call 911 (Emergency Medical Services) and the student's parents/guardian.
- Contact 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 orders below).

For insulin pump users: see additional information for student with insulin pump.

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 page 7).

- Notify parents/guardian of onset of hyperglycemia.
- If the student has symptoms of a hyperglycemia emergency, including 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: Call 911 (Emergency Medical Services) and the student's parents/ guardian.
- Contact student's health care provider.

INSULIN THERAPY

Insulin delivery device: ☐ syringe ☐ insulin pen ☐ insulin pump

Type of insulin therapy at school:

☐ Adjustable Insulin Therapy
☐ Fixed Insulin Therapy
☐ No insulin

Adjustable Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:**

  Name of insulin: ______________________________

- **Carbohydrate Coverage:**

  Insulin-to-Carbohydrate Ratio:

  Lunch: 1 unit of insulin per ______ grams of carbohydrate

  Snack: 1 unit of insulin per_______ grams of carbohydrate

Carbohydrate Dose Calculation Example

$$\frac{\textit{Grams of carbohydrate in meal}}{\textit{Insulin-to-carbohydrate ratio}} = ______ \text{ units of insulin}$$

- **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor =_________

Target blood glucose =_________ mg/dL

Correction Dose Calculation Example

$$\frac{\textit{Actual Blood Glucose—Target Blood Glucose}}{\textit{Blood Glucose Correction Factor/Insulin Sensitivity Factor}} = _______ \text{units of insulin}$$

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

INSULIN THERAPY (Continued)

When to give insulin:

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.

☐ Other: ____

☐ 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-lunch daily

☐ _____Units of insulin given pre-snack daily

☐ Other: ____

Parental Authorization to Adjust Insulin Dose:

☐ Yes ☐ No Parents/guardian authorization should be obtained before administering a correction dose.

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- _____units of insulin.

☐ Yes ☐ No Parents/guardian 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/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

INSULIN THERAPY (Continued)

Student's self-care insulin administration skill

☐ Yes ☐ No Independently calculates and gives own injections
☐ Yes ☐ No May calculate/give own injections with supervision
☐ Yes ☐ No Requires school nurse or trained diabetes personnel to calculate/give injections

ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP

Brand/Model of pump: ___________________ Type of insulin in pump: _______________

Basal rates during school: ____

Type of infusion set: ____

☐ For blood glucose greater than ________mg/dL that has not decreased within _______ hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir.

☐ 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 ☐ No
Set a temporary basal rate ☐ Yes ☐ No_______ % temporary basal for _____ hours
Suspend pump use ☐ Yes ☐ No

Student's self-care pump skills:	**Independent?**
Count carbohydrates	☐ Yes ☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes ☐ No
Calculate and administer correction bolus	☐ Yes ☐ No
Calculate and set basal profiles	☐ Yes ☐ No
Calculate and set temporary basal rate	☐ Yes ☐ No
Change batteries	☐ Yes ☐ No
Disconnect pump	☐ Yes ☐ No
Reconnect pump to infusion set	☐ Yes ☐ No
Prepare reservoir and tubing	☐ Yes ☐ No
Insert infusion set	☐ Yes ☐ No
Troubleshoot 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/guardian discretion
☐ Student discretion

Student's self-care nutrition skills:

☐ Yes ☐ No Independently counts carbohydrates

☐ Yes ☐ No May count carbohydrates with supervision

☐ Yes ☐ No 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 ☐ 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.

(Additional information for student on insulin pump is in the insulin section on page 6.)

DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follows: ____

☐ 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:) __________________'s 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