

Cherry Hill Public Schools

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. (adapted from www.YourDiabetesInfo.org Helping the Student with Diabetes Succeed)

Date of Plan: _____ School year: _____ - _____

Student's Name: _____ Date of Birth: _____

Date of Diabetes Diagnosis: _____ type 1 type 2 Other _____

School: _____ School Phone Number: _____

Grade: _____ Homeroom/Team/LC: _____

School Nurse: _____ Phone: _____

CONTACT INFORMATION

1. Parent/Guardian: _____

Address: _____

Parent/guardian contact number 1: _____

Parent/guardian contact number 2: _____

Email Address: _____

2. Parent/Guardian: _____

Address: _____

Parent/guardian contact number 1: _____

Parent/guardian contact number 2: _____

Email Address: _____

Student's Physician/Health Care Provider: _____

Address: _____

Telephone: _____

Email Address: _____

Other Emergency Contacts:

Name: _____ Relationship: _____

Contact number: _____

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)

Use CGM for insulin coverage: Yes No

Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If the 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: _____

Follow physical activity and sports orders (see page 6).

- 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: _____
 - Intranasal Glucagon: _____

- Call 911 (Emergency Medical Services) and the student's parents/guardian.
- 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 orders below)

For insulin pump users: see additional information for students with insulin pump on page 5-6.

Give extra water and/or *non-sugar-containing* drinks: _____ ounces per hour

Additional treatment for ketones: _____

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

- Notify parent/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, shortness of breath, chest pain, increasing sleepiness or lethargy, depressed level of consciousness: Call 911 (Emergency Medical Services) and the student's parent/guardian.
- Contact the 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

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

- **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor= _____

Target blood glucose = _____ mg/dL

Correction Dose Calculation Example

$$\frac{\text{Actual Blood Glucose} - \text{Target Blood Glucose}}{\text{Blood Glucose Correction Factor/Insulin Sensitivity Factor}} = \text{_____ units of insulin}$$

Correction dose scale:

(use instead of calculation above to determine correct insulin 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 skills:

- 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 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 a student on insulin pump is in the insulin section on page 5-6.)

DISASTER PLAN

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

- Continue to follow orders contained in this DMMP
- Additional insulin orders as follows: _____
- Other: _____

