

Diabetes Medical Management Plan (DMMP)

(adapted from NDEP- National Diabetes Education Program)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with the relevant CTY staff and should be kept in a place that can be accessed easily by the site health staff and authorized administrators and staff. Please note that ALL medications (including insulin) that your child is taking must be entered on their CampDoc CTY Medical Form. This management plan is for site health staff to reference as needed, but medications are only administered per the CTY Medical Form.

Part 1

Student Information

Student's name: _____ CTY ID: _____

Date of Birth: _____ Date of diabetes diagnosis: _____
(mm/dd/yyyy) (mm/dd/yyyy)

Diabetes Diagnosis: ☐ Type 1 ☐ Type 2 ☐ Other: _____

CTY Site Location: _____

Diabetes Health Provider Contact Information

Provider's Name: _____

Provider's Address: _____

Provider's phone number: _____ Provider's Emergency number: _____

Email address of provider: _____

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:

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 health staff or trained diabetes personnel to check blood glucose
- ☐ Uses smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM):

Does the student use a continuous glucose monitor? ☐ Yes ☐ No (if No, skip to Part 2)

Brand/model if yes: _____

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 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 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 parent/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 blood glucose level.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The student should be escorted to the health office if the CGM alarm goes off: ☐ Yes ☐ No

Other instructions for the health team: _____

Part 2: Treatment Protocols for Hypo- and Hyperglycemia

Hypoglycemia treatment

Student's usual symptoms of hypoglycemia: _____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL,

1. Give a quick-acting glucose product equal to _____ grams of carbohydrate.
Usual quick-acting glucose source: _____
2. Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.
3. Additional treatment: _____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

1. Position student on his or her side to prevent choking.
2. Give glucagon: ☐ 1mg ☐ ½ mg ☐ Other dose: _____
 - o Route: ☐ subcutaneous (SC) ☐ Intramuscular (IM)
 - o Site of glucagon injection: ☐ Buttock ☐ Arm ☐ Thigh ☐ Other: _____
3. Call 911 (Emergency medical services) and the student's parents/guardians.
4. Contact the student's health care provider.

Hyperglycemia treatment

Student's usual symptoms of hyperglycemia: _____

1. Check ☐ Urine ☐ Blood for ketones every _____ hours when blood glucose levels are above _____ mg/dL.
2. For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
3. Notify parents/guardians if blood glucose is over _____ mg/dL.
4. For insulin pump users: see ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP.
5. Allow unrestricted access to the bathroom.
6. 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 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.

Part 3: Nutrition and Activity

Student's self-care nutrition skills	
Independently counts carbohydrates	<input type="checkbox"/> Yes <input type="checkbox"/> No
May count carbohydrates with supervision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requires school nurse/trained diabetes personnel to count carbohydrates	<input type="checkbox"/> Yes <input type="checkbox"/> No

Meal Plan

Meal/Snack	Time	Carbohydrate Content
Breakfast		_____to_____grams
Mid-morning snack		_____to_____grams
Lunch		_____to_____grams
Mid-afternoon snack		_____to_____grams
Dinner		_____to_____grams
Evening snack		_____to_____grams
Other		_____to_____grams

Other instructions for food/snacks (i.e., when food is provided for an activity): _____

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 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).

Other diabetes medications if applicable (These MUST be noted on the student's CTY Medical Form.)

Name:_____Dose:_____Route:_____Times given: _____

Name:_____Dose:_____Route:_____Times given: _____

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: _____

☐ Other: _____

Part 4: Insulin Therapy

Insulin delivery device: ☐ Syringe ☐ Insulin pen ☐ Insulin pump ☐ None

Type of insulin therapy at CTY:

- ☐ Adjustable (basal-bolus) insulin → Continue to Part 5
- ☐ Fixed insulin therapy → Skip to Part 6
- ☐ Insulin Pump → Skip to Part 7
- ☐ No insulin → Skip to Part 8

Adjustable (Basal-bolus) Insulin Therapy

Carbohydrate Coverage & Correction Dose Instructions

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	
$\frac{\text{Total Grams of Carbohydrate to Be Eaten}}{\text{Insulin to Carbohydrate Ratio}} = \text{_____ Units of Insulin}$	

Correction dose

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

Correction Dose Calculation Example	
$\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Correction Factor}} = \text{_____ Units of Insulin}$	

Correction dose scale (used instead of calculation above to determine 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 Corrections Factors (<https://www.wcu.edu/WebFiles/PDFs/6403AdvancedInsulinManagementFinal.pdf>) for instructions on how to compute the insulin dose using a student's insulin-to-carb ratio and insulin correction factor.

Schedule

- 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: _____
- Dinner** ☐ 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-dinner daily

☐ ____ Units of insulin given pre-snack daily

☐ Other: _____

Parents/Guardians Authorization to Adjust Insulin Dose:

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.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Student's self-care insulin administration skills:

└ Independently calculates and gives own injections.

└ May calculate/give own injections with supervision.

└ Requires nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.

└ Requires nurse or trained diabetes personnel to calculate dose and give the injection.

Physical Activity

May disconnect from pump for sports activities: ☐ No ☐ Yes, for ____ hours

Set temporary basal rate: ☐ No ☐ Yes, ____% temporary basal for ____ hours

Suspend pump use: ☐ No ☐ Yes, for ____ hours

Additional information for student with insulin pump:

Brand/model of pump: _____ **Type of insulin pump:** _____

Basal rates during school:

Time: _____ Basal rate: _____

Time: _____ Basal rate: _____

Time: _____ Basal rate: _____

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.

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

Signatures

This Diabetes Medical Management Plan has been approved by:

_____	_____
Student's Physician/Diabetes Health Care Provider	Date

I, (parent/guardian)_____, give permission to the CTY health and administrative staff or another health care professional or trained diabetes personnel 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 information contained in this Diabetes Medical Management Plan to all CTY 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 site nurse/health staff 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