



## DIABETES MEDICAL MANAGEMENT PLAN (DMMP) For Student Requiring Insulin Therapy

This plan should be completed by the student's parent(s)/guardian(s) and the diabetes health care team. 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, delegated diabetes care aide, and other authorized personnel.

Date of Plan: \_\_\_\_\_

This plan is valid for school year: \_\_\_\_\_ - \_\_\_\_\_

Student: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date: \_\_\_\_\_  
School: \_\_\_\_\_ School Phone #: \_\_\_\_\_  
School Phone #: \_\_\_\_\_

### Diabetes Health Care Provider:

Name: \_\_\_\_\_ Office Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Email: \_\_\_\_\_

---

**Monitor Blood Glucose:**  Before breakfast  Before lunch  Before PE  After PE  
 As needed for symptoms of low or high blood glucose or illness  
 Before leaving to get on bus/going home

Target range for blood glucose: \_\_\_\_\_ to \_\_\_\_\_ mg/dL      Site of testing: Fingertip

- Mid-morning snacks, if desired, should be eaten at least two hours prior to lunch.
- Blood glucose taken less than two hours after carbohydrate consumption/insulin administration should NOT be corrected.

Continuous Glucose Monitor (CGM): Brand/Model: \_\_\_\_\_

---

**Hypoglycemia:** Blood glucose reading less than 70mg/dL.

**Student should not be left alone if blood glucose is less than 70mg/dL and/or has symptoms of low blood glucose.**

**Mild symptoms:** Student is alert and shows signs of: (circle appropriate symptoms) shakiness, dizziness, sweating, extreme hunger, headache, pale skin color, behavioral changes, other: \_\_\_\_\_

**Treatment:**

- Give 15 grams rapid-acting carbohydrate (i.e. glucose tabs, fruit juice, Smarties®, granulated sugar) with NO insulin.
- Recheck blood glucose in 15 minutes after treating. Repeat treatment if blood glucose is less than 70mg/dL and/or symptoms persist.

**Moderate symptoms:** Student shows signs of severe confusion, disorientation, not able to or unwilling to swallow, may be combative

**Treatment:**

- Keeping head elevated, give 15 grams carbohydrate using glucose/icing gel applied between cheek and gum.
- Recheck blood glucose in 15 minutes after treating. Repeat treatment if blood glucose is less than 71mg/dL and/or symptoms of hypoglycemia persist.

**Severe symptoms:** Seizures, unconsciousness, unable or unwilling to swallow

**Treatment:**

- Administer Glucagon \_\_\_\_\_mg intramuscularly (IM) in buttock or thigh and place student lying on his/her side as vomiting may occur. Contact parent/guardian.
- Call 9-1-1 as specified in district protocol, or 504 Health Plan.

**Hyperglycemia:** Any blood glucose reading above target blood glucose.

**Allow student bathroom privileges and water access as needed.**

**Treatment:**

- Give student water to drink.
- Give correction insulin dose as specified in DMMP.
- Check for urine ketones if student has one or more of the following:  
nausea vomiting headache "feels sick" stomach pain  
unexpected blood glucose above 250 mg/dL

When **trace of small** urine ketones are present:

**Treatment:**

- Contact parent/guardian as specified in DMMP or 504 Health Plan.
- Push fluids: 8 ounces of water every 30-60 minutes.
- Check blood glucose and urine ketones every two hours.
- Give correction insulin dose using rapid-acting insulin every two hours if blood glucose is above target.

When **moderate to large** ketones are present:

**Treatment:**

- Follow the instructions for trace or small urine ketones **AND** do the following:
  - If blood glucose is less than 150mg/dL, treat with 15 grams of carbohydrates every 15 minutes until the blood glucose is equal to or greater than 150 mg/dL.
  - Once/when blood glucose is 150mg/dL or more, calculate correction insulin dose for current blood glucose. Next calculate the ketone treatment insulin dose using the following:
    - For **moderate** urine ketones: Multiply the correction insulin dose by **1.5**
    - For **large** urine ketones: Multiply correction insulin dose by **2.0**
  - Calculate food insulin dose for any carbohydrates eaten after blood sugar is greater than 150mg/dL, and add to the above ketone treatment insulin dose.
  - Administer insulin by syringe or insulin pen **even if on insulin pump**.
  - If on insulin pump therapy, consider/do an infusion site change.
  - Avoid physical activity.
  - Recheck blood glucose and urine ketones **every two hours**. Repeat treatment until ketones are small, trace, or none.
  - **Call 9-1-1 if student has any of the following symptoms: chest pain, shortness of breath, heavy breathing, and/or decreased level of consciousness.**

---

**Diet**    Count Carbohydrates in foods/beverages. Total grams of carbohydrate student eats at meal times can vary.

Gluten-free restriction.

---

### Diabetes Supplies

The following diabetes supplies and equipment necessary to monitor and treat diabetes, should be possessed on student's person and/or kept in close proximity to student at all times.

glucometers	lancets/lancing device	test strips	insulin
batteries/charge	ketone test strips	food/drink/snacks	glucagon injection kit
syringes/insulin pens & pen needles		rapid-acting carbohydrate	food/glucose tablet

For student on insulin pump therapy, additional supplies to be kept at school include: alcohol wipes, insulin pump/PDM, infusion sets/pods, and/or cartridges, reservoirs, tubing, and insertions device.

*Handling of used syringes, pen needles, lancets, non-contained infusion set devices, and other sharps should be in accordance to FDA guidelines.*

\*\*Parent/Guardian and student are responsible for maintaining necessary diabetes supplies, equipment, medications and/or snacks at school.

---

### Medication

Administer insulin before meals **AND** snacks unless specified differently in treatment plan, or 504 Health Plan. If using injection therapy, calculate insulin doses for routine snacks as specified in DMMP or 504 Health Plan.

Rapid-acting insulin type: \_\_\_\_\_  
Given by :  syringe  insulin pen  insulin pump: \_\_\_\_\_

### Dose information for rapid-acting insulin:

**Carbohydrate counting:** Give 1 units rapid-acting insulin per specified grams of carbohydrate

Insulin-to-carbohydrate ratio:

Breakfast: 1 unit: \_\_\_\_\_ grams

Mid-morning snack: 1 unit: \_\_\_\_\_ grams

Lunch: 1 unit \_\_\_\_\_ grams

Afternoon snack: 1 unit: \_\_\_\_\_ grams

### Blood Glucose Correction:

Blood glucose target: \_\_\_\_\_ mg/dL Correction/sensitivity factor: 1units/ \_\_\_\_\_

### How to calculate rapid-acting insulin doses at meal times:

#### Food insulin dose:

Total grams carbohydrate in meal ÷ Insulin-to-carbohydrate ration = Units Insulin for food

#### Correction insulin dose:

High blood glucose reading – Blood glucose target ÷ Correction factor/Sensitivity factor  
= Units insulin for correction

#### Total insulin dose:

Food insulin dose + Correction insulin dose = Total units of insulin

*Insulin pump will calculate insulin dose when blood glucose and/or total grams of carbohydrates are entered into pump. See pump settings for insulin dose information.*

---

### Student's Self Care Skills

**Students shall have access to supervision/assistance by properly trained school personnel. Levels of required supervision/assistance should be individualized by health care provider, parent/guardian and school.**

- Requires school nurse/diabetes care aide to calculate dose, draw up insulin, and/or given injection/bolus
- May give own injections; requires school nurse/diabetes care aide to calculate dose and/or draw up insulin
- May calculate dose, draw up insulin and/or give own injections/bolus with supervision
- Student independently self-manages diabetes, requiring assistance only for emergency care.

**Yes**  **No** Parent/guardian authorized to increase or decrease correction factor, insulin-to-carbohydrate ratio, and/or blood glucose target as needed.

**Other**

---

---

---

---

- **Call 9-1-1 (Emergency Medical Services)** if student has any of the following symptoms:

<b>EMERGENCY SYMPTOMS</b>	
<i>chest pain</i>	<i>shortness of breath</i>
<i>heavy breathing</i>	<i>deceased level of consciousness</i>

---

**Physical education class (PE)**

**If blood glucose is checked at time of PE:**  Does not apply

Student may participate in PE when blood glucose is greater than \_\_\_\_\_ mg/dl. If blood glucose is greater than 70 m/dl but less than \_\_\_\_\_ mg/dl, give \_\_\_\_\_ grams of rapid-acting glucose product before student participates in physical activity.

---

**SCHOOL DISASTER PLAN/LOCK DOWN**

- Parent/guardian should provide school with diabetes supplies for use during a disaster or emergency prior to the event.
- Follow instructions as specified in this Diabetes Medical Management Plan of 504 Health Plan
- Student should have access to all diabetes supplies.

---

**CONTACT INFORMATION**

**Parent(s)/Guardian(s) Name:** \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

If different from above:

**Parent(s)/Guardian(s) Name:** \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Other Emergency Contact:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

---

---

**SIGNATURES**

My signature below provides authorization for the above written orders and exchange of health information to assist the school nurse/trained diabetes care aide/school administrator in developing an individualized 504 Health Plan.

Physician/Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

As parent/guardian of the above name student, I give my permission to the school nurse/diabetes care aide/school administrator or other trained designated staff to perform and carry out the diabetes tasks as outlined in this Diabetes Medical Management Plan and/or 504 Medical Plan and for my child's healthcare provider to share information with the school for completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to know basis. It is the responsibility of the parent/guardian to notify the school whenever there is any change in the student's health status or care. The school may contact parent/guardian if questions regarding diabetes care arise. I also give the school permission to contact my child's health care provider.

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

School Representative: \_\_\_\_\_ Date: \_\_\_\_\_