



This plan should be completed by the child’s personal diabetes health care team, including the parents/guardian. It should be reviewed with relevant program staff and copies should be kept in a place that can be accessed easily by the program nurse, trained diabetes personnel, and other authorized personnel.

Date of plan: _____ This plan is valid for the current year: _____

Child’s Name: _____ Date of Birth: _____

Date of Diabetes Diagnosis: _____ type 1 type 2 Other

Program: _____ Program Phone Number: _____

Age Group: _____ Classroom Teacher: _____

MAT Diabetes certified staff or other qualified health care professional:

Phone: _____

CONTACT INFORMATION

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell: _____

Email Address: _____

Father/ Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell: _____

Email Address: _____

Child’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 physical activity (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.

Child’s self-care blood glucose checking skills:

Independently checks own blood glucose

May check blood glucose with supervision

Requires child day program administrator/director or MAT Diabetes certified staff 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 child has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

HYPOGLYCEMIA TREATMENT

Child’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 child is unable to eat or drink, is unconscious or unresponsive, or is having seizures activity or convulsions (jerking movements), give:
- Glucagon: 1 mg ½ mg Route: SC(subcutaneous) IM(intramuscular)
- Site for glucagon injection: arm thigh Other: _____
- Call 911 (Emergency Medical Services) and the child’s parents/guardian.
- Contact child’s health care provider.

HYPERGLYCEMIA TREATMENT

Child’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 a child 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 child has symptoms of 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 child’s parents/guardian.
- Contact child’s health care provider.



Insulin therapy

Insulin delivery device: syringe insulin pen insulin pump

Type of insulin therapy at the child day program:

- Adjustable Insulin Therapy
- Fixed Insulin Therapy
- No insulin

Adjustable Insulin Therapy

- **Carbohydrate Coverage/ Correction Dose:**

Name of insulin: _____

Meal Matrix (see Correction Matrix for Dosage Adjustments)

Meal	Grams Carbs	Insulin Dose in Units	Meal	Grams Carbs	Insulin Dose in Units

- **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 matrix (use instead of calculation below to determine insulin correction dose):

Blood Glucose	Correction Dose in Units
___ to ___ mg/dL	
___ to ___ mg/dL	
___ to ___ mg/dL	
___ to ___ mg/dL	



• **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor= _____

Target blood glucose= _____ mg/dL

Correction Dose Calculation Example

____ *Actual Blood Glucose* – ____ *Target Blood Glucose*

____ *Blood Glucose Correction Factor/Insulin Sensitivity Factor* = _____ units of insulin

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.
- 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: _____



Parent 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.

Child's self-care insulin administration skills:

- Yes No Independently calculates and give own injections
- Yes No May calculate/give own injections with supervision
- Yes No Requires child day program administrator/director or MAT Diabetes certified staff to calculate/give injections

ADDITIONAL INFORMATION FOR CHILD WITH INSULIN PUMP

Brand/Model of pump _____ Type of insulin in pump: _____

Basal rates during program: _____

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 fusion 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



Independent?

Child's self-care pump skills:

- Counts 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
 Child discretion



Child's self-care nutrition skills:

- Yes No Independently counts carbohydrates
- Yes No May count carbohydrates with supervision
- Yes No Requires MAT Diabetes certified staff or other qualified health care professional 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.

Child should eat 15 grams 30 grams of carbohydrates other before every 30 minutes during after vigorous physical activity other: _____

If most recent blood glucose is less than _____ mg/dL, child can participate in physical activity when blood glucose is correct 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 child 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:

Child’s Physician/Health Care Provider: _____

Date: _____

I, (parent/guardian:) _____ give permission to the MAT Diabetes certified staff or other qualified health care professional of (program:) _____ to perform and carry out the diabetes care tasks as outlined in (child:) _____’s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all program 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 MAT Diabetes certified staff or other qualified health care professional to contact my child’s physician/health care provider.

Acknowledged and received by:

Child’s Parent/Guardian Date

Child’s Parent/Guardian Date

Program Nurse/Other Qualified Health Care Personnel Date