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 heath 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 |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |

* **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**

= units of insulin

***\_\_\_ Grams of carbohydrate in meal***

***\_\_\_ Insulin-to-carbohydrate ratio***

**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**

**=** units of insulin

***\_\_\_ Actual Blood Glucose – \_\_\_Target Blood Glucose***

***\_\_\_ Blood Glucose Correction Factor/Insulin Sensitivity Factor***

**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

|  |  |
| --- | --- |
| **Child’s self-care pump skills:** | **Independent?** |
| 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