YMCA of the Fox Cities
Diabetes Medical Management Plan (DMMP)

Date of Plan:_____ This plan is valid for the following period:____ - _____

Participant's Name:_____Date of Birth:_____

Date of Diabetes Diagnosis:_____ ❑ type 1 ❑ type 2 ❑ Other_____

School/Program:_____ Program Phone Number:_____

Grade:_____ Program Site Director:_____

YMCA Program Director/Coordinator (if applicable):_____

Phone:_____

CONTACT INFORMATION

Mother/Guardian:_____

Address:_____

Telephone: Home_____Work _____Cell:_____

Email Address:_____

Father/Guardian: Address: _____

Telephone: Home_____Work_____Cell:_____

Email Address:_____

Participant'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 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.

Participant's self-care blood glucose checking skills:

❑ Independently checks own blood glucose

❑ May check blood glucose with supervision

❑ Requires YMCA Program Director/Coordinator (if identified above) or trained diabetes personnel 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 participant has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

HYPOGLYCEMIA TREATMENT

Participant'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 participant 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:_____
- Contact participant's health care provider.

HYPERGLYCEMIA TREATMENT

Participant'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 participant 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 participant has symptoms of a 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 participant's parents/guardian.
- Contact participant'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

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

- **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____

Target blood glucose = _____ mg/dL

Carbohydrate Dose Calculation Example

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

Correction dose scale (use instead of calculation above to determine insulin 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

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)

Participant'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 YMCA Program nurse (if identified above) or trained diabetes personnel to calculate/give injections

ADDITIONAL INFORMATION FOR PARTICIPANT 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

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

Participant's self-care pump skills:	**Independent?**
Count 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
❑ Participant discretion

Participant's self-care nutrition skills:

❑ Yes ❑ No Independently counts carbohydrates

❑ Yes ❑ No May count carbohydrates with supervision

❑ Yes ❑ No Requires YMCA Program nurse (if identified above)/trained diabetes personnel 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.

Participant 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, participant 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 participant 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 DMMR

❑ Additional insulin orders as follows:_____

❑ Other:_____

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

_____

Participant's Physician/Health Care Provider Date

I, (parent/guardian:) _____ give permission to the YMCA Program staff or another qualified health care professional (if identified above) or trained diabetes personnel of the YMCA of the Fox Cities ("YMCA") to perform and carry out the diabetes care tasks as outlined in (participant:)_____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all YMCA 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 YMCA Program staff or another qualified health care professional (if identified above) to contact my child's physician/health care provider.

_____

Acknowledged and received by:

_____

Participant's Parent/Guardian Date

_____

Participant's Parent/Guardian Date

If applicable: YMCA Program Director/Coordinator/ Other Qualified Health Care Personnel — Date

If applicable: Trained Diabetes Personnel — Date