

Diabetes Medical Management Plan (DMMP)

This plan should be completed by the camper's personal diabetes health care team, including the parents/guardian. **Please return by May 1 to Camp Foley.**

Date of Plan: _____ This plan is valid for the camp session: _____

Camper's Name: _____ Date of Birth: _____

Date of Diabetes Diagnosis: _____ type 1 type 2 Other _____

CONTACT INFORMATION

Parent 1's Name: _____

Primary Phone: _____ Second Phone: _____

Parent 2's Name: _____

Primary Phone: _____ Second Phone: _____

Diabetes Physician/Health Care Provider: _____

Primary Phone: _____ Emergency Phone: _____

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CHECKING BLOOD GLUCOSE

Target range of blood glucose: 70-130 mg/dL 70-180 mg/dL

Other: _____

Check blood glucose level:

Before breakfast _ _ _ Hours after breakfast

Before lunch _ _ _ Hours after lunch

Before dinner _ _ _ Hours after dinner

Before bed

2 hours after a correction dose

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.

Camper's self-care blood glucose checking skills:

Independently checks own blood glucose

May check blood glucose with supervision

Requires camp nurse 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 camper has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM

HYPOGLYCEMIA TREATMENT

Camper'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 camper 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: _____
- Call 911 (Emergency Medical Services) and the camper's parents/guardian.
- Contact camper's health care provider.

HYPERGLYCEMIA TREATMENT

Camper'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 camper 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 camper 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 camper's parents/guardian.
- Contact camper's health care provider.

INSULIN THERAPY

Insulin delivery device: syringe insulin pen insulin pump

Type of insulin therapy at camp:

- Adjustable Insulin Therapy
 Fixed Insulin Therapy

Adjustable Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:**

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

Supper: 1 unit of insulin per _____ grams of carbohydrate

Snack: 1 unit of insulin per _____ grams of carbohydrate

Other _____: 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:**

Correction Dose Calculation Example

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

Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____

Target blood glucose = _____ mg/dL

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:

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: _____

Supper

- 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)

Camper's self-care insulin administration skill

- Yes No Independently calculates and gives own injections
- Yes No May calculate/give own injections with supervision
- Yes No Requires camp nurse or trained diabetes personnel to calculate/give injections

ADDITIONAL INFORMATION FOR CAMPER WITH INSULIN PUMP

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

Basal rates during camp: _____

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

Camper's self-care pump skills:

Independent?

- | | |
|---|--|
| Count carbohydrates | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bolus correct amount for carbohydrates consumed | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Calculate and administer correction bolus | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Calculate and set basal profiles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Calculate and set temporary basal rate | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Change batteries | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Disconnect pump | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reconnect pump to infusion set | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prepare reservoir and tubing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Insert infusion set | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Troubleshoot alarms and malfunctions | <input type="checkbox"/> Yes <input type="checkbox"/> No |

OTHER DIABETES MEDICATIONS

Name: _____ Dose: _____ Route: _____ Times given: _____
Name: _____ Dose: _____ Route: _____ Times given: _____

MEAL PLAN

Meal/Snack	Time	Carbohydrate Content (grams)
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Breakfast	_____	_____ to _____
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Mid-morning snack	_____	_____ to _____
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Lunch	_____	_____ to _____
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Mid-afternoon snack	_____	_____ to _____
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Supper	_____	_____ to _____
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Evening snack	_____	_____ to _____
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Other times to give snacks and content/amount: _____

Camper's self-care nutrition skills:

Yes No Independently counts carbohydrates

Yes No May count carbohydrates with supervision

Yes No Requires camp nurse/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.

Camper 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, camper 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 camper 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:

Camper's Physician/Health Care Provider Date

I, (parent/guardian:) _____ give permission to the camp nurse or another qualified health care professional or trained diabetes personnel of (camp:) _____ to perform and carry out the diabetes care tasks as outlined in (camper:) _____ 's Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all camp 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 camp nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

Camper's Parent/Guardian Date

Camper's Parent/Guardian Date

Camp Nurse/Other Qualified Health Care Personnel Date