FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA of Metro Chicago
DIABETES MEDICAL MANAGEMENT PLAN (DMMP)

Date of Plan ____/____/____ Plan Effective Dates: ____/____/____ through ____/____/____

MEMBER INFORMATION PLEASE PRINT

First Name ______________________ Last Name ______________________ Date of Birth ___/___/___

Date of diabetes diagnosis ______________________ ☐ Type 1 ☐ Type 2 Other ______________

YMCA Center/Site ____

CONTACT INFORMATION

Parent/Guardian 1

Name ____

Address ____

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Email ____

Parent/Guardian 2

Name ____

Address ____

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Email ____

Member's physician/health care provider

Name ____

Address ____

Telephone ______________________ Emergency Phone ______________________

Other Emergency Contact

Name ______________________________ Relationship ______________

Address ____

Telephone ______________________ Emergency Phone ______________________

Email ____

BLOOD GLUCOSE MONITORING

Brand/model of blood glucose meter ____

Target range of blood glucose Before Meals ☐ 90–130 mg/dL ☐ Other____________

Check blood glucose level

☐ Before breakfast ☐ After breakfast ☐ __Hours after breakfast ☐ 2 Hours after correction dose

☐ Before Lunch ☐ After lunch ☐ __Hours after lunch ☐ Before snacks

☐ Mid-morning ☐ Before physical activity/exercise ☐ After physical activity/exercise

☐ As needed for signs/symptoms of low or high blood glucose ☐ As needed for signs/symptoms of illness

☐ Other (Please explain) ____

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Preferred site of testing ☐ Side of fingertip ☐ Other ____

Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Member's self-care blood glucose checking skills:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires a trained diabetes personnel to check blood glucose

☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM) ☐ No ☐ Yes Brand/model: ________________________________

Alarms set for Severe Low ____________ Low ____________ High ____________

Predictive alarm Low ____________ High ____________ Rate of Change Low ____________ High ____________

Threshold suspend setting ____

ADDITIONAL INFORMATION FOR MEMBER WITH CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level. If the member has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the member or parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the member's device.

Independent Self-care CGM Skills

The member troubleshoots alarms and malfunctions ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

The member knows what to do and is able to deal with a HIGH alarm ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

The member knows what to do and is able to deal with a LOW alarm ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

The member can calibrate the CGM ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

The member knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level. ☐ Yes ☐ No, Needs Assistance (if so please describe) ____

HYPOGLYCEMIA TREATMENT

Member'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 15 minutes and repeat treatment if blood glucose level is less than ____ mg/dL.
Additional treatment: ____

If the member is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- Position the student on his or her side to prevent choking.
- Give glucagon ☐ 1 mg ☐ ½ mg ☐ Other (dose)

  Route ☐ Subcutaneous (SC) ☐ Intramuscular (IM)

  Site for glucagon injection ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other
- Call 911 (Emergency Medical Services) and the member's parents/guardians.
- Contact the member's health care provider.

HYPERGLYCEMIA TREATMENT

Member'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 correction dose orders).
- Notify parents/guardians if blood glucose is over ____ mg/dL.
- For insulin pump users: see Additional Information for Member with Insulin Pump.
- Allow unrestricted access to the bathroom.
- 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 **Physical Activity and Sports**)

If the member has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the member's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: 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.

INSULIN THERAPY

Insulin delivery device ☐ Syringe ☐ Insulin pen ☐ Insulin pump
Type of insulin therapy at program: ☐ Adjustable (basal-bolus) insulin ☐ Fixed insulin therapy ☐ No insulin

Adjustable (Basal-bolus) 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

  Snack: 1 unit of insulin per ____ grams of carbohydrate

Carbohydrate Dose Calculation Example
$\frac{\text{Total Grams of Carbohydrate to Be Eaten}}{\text{Insulin -to-Carbohydrate Ratio}}$ = ________________Units of Insulin

Correction dose: Blood glucose correction factor (insulin sensitivity factor) = ____ Target blood glucose = ____ mg/dL

Correction Dose Calculation Example
$\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Current Blood Glucose} - \text{Target}}$ = ________________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

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:__________

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 ____

☐ Yes ☐ No Parents/guardians authorization should be obtained before administering a correction dose.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/– ____ units of insulin.

☐ Yes ☐ No Parents/guardians 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/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/– ____ units of insulin.

Member's self-care insulin administration skills

☐ Independently calculates and gives own injections.
☐ May calculate/give own injections with supervision.
☐ Requires trained diabetes personnel to calculate dose and student can give own injection with supervision.
☐ Requires trained diabetes personnel to calculate dose and give the injection.

ADDITIONAL INFORMATION FOR MEMBER WITH INSULIN PUMP

Brand/model of pump: ____ Type of insulin in pump: ________________

Basal rates during school: Time: ______ Basal rate: ______ Time: ______ Basal rate: ______
Time: ______ Basal rate: ______ Time: ______ Basal rate: ______
Time: ______ Basal rate: ______

Other pump instructions: ____

Type of infusion set:____

Appropriate infusion site(s): ____

☐ For blood glucose greater than _____mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.

☐ 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, for ____ hours ☐ No

Set a temporary basal rate: ☐ Yes, _____ % temporary basal for ____ hours ☐ No

Suspend pump use: ☐ Yes, for ____ hours ☐ No

Independent Self-care Pump Skills

Counts Carbohydrates ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

Calculates correct amount of insulin for carbohydrates consumed ☐ Yes ☐ No, Needs Assistance (if so please describe) ____

Administers correction bolus ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

Calculates and sets basal profiles ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

Calculates and sets temporary basal rate ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

Changes batteries ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

Disconnects pump ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

Reconnects pump ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

Prepares reservoir, pod, and/or tubing ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

Inserts infusion set ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

Troubleshoots alarms and malfunctions ☐ Yes ☐ No, Needs Assistance (if so please describe)

____

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 program (e.g., as part of a party or food sampling event): ____________

____

Special event/party food permitted: ☐ Parents'/Guardians' discretion ☐ Member's discretion

Member's self-care nutrition skills:
☐ Independently counts carbohydrates
☐ May count carbohydrates with supervision
☐ Requires 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.

Member should eat ☐ 15 grams ☐ 30 grams of carbohydrate ☐ other: ____
☐ before ☐ every 30 minutes during ☐ every 60 minutes during ☐ after vigorous physical activity
☐ other: ______________________

If most recent blood glucose is less than ______ mg/dL, member 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.

DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

☐ Continue to follow orders contained in this DMMP.
☐ Additional insulin orders as follows (e.g., dinner and nighttime): ______________________

____

☐ Other: ____

EQUIPMENT AND SUPPLIES

List equipment and supplies to be kept on-site and on the member's person.

On-Site	On the member

Location of on-site equipment and supplies (to be determined and filled in at staff training): ______________________________

____

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

____

Member's Physician/Health Care Provider Date

I acknowledge that the YMCA of Metropolitan Chicago will use the information provided in this Diabetes Medical Management Plan (DMMP) to make an individualized determination about whether program staff will provide the requested assistance based on the specific circumstances of this request.

I acknowledge that any agreed upon assistance will be outlined in the YMCA of Metropolitan Chicago's Inclusion Plan for (member)____

I, (parent/guardian) ____________________________________, give permission to the trained diabetes personnel of YMCA Center ____to perform and carry out the diabetes care tasks as agreed upon and outlined in the Inclusion 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 a representative of the YMCA to contact my child's physician/health care provider.

Acknowledged and received by:

____

Member's Parent/Guardian Date

____

Member's Parent/Guardian Date

____

YMCA Representative Date

THIS PLAN HAS BEEN REVIEWED WITH RELEVANT YMCA OF METROPOLITAN CHICAGO STAFF:

Staff Name (print)	Title	Date

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