Patient:_____ Date of Birth: _____ Effective Date: 2016 – 2017 School Year

Virginia School Diabetes Medical Management Plan (DMMP)
Part 1
Contact Information and Medical History

Virginia Diabetes Council - School Diabetes Care Practice and Protocol - Provides guidelines, recommended accommodations and references applicable to all students with diabetes. This document is electronically available: **http://www.virginiadiabetes.org**

Instructions: Parent / Guardian to complete form. Thank you.

School: Grade:

Homeroom Teacher: Effective Date :

Parent/Guardian #1:

Address: Telephone:

Email:

Parent/Guardian #2:

Address: Telephone:

Email:

Other emergency contact:

Address: Telephone:

Email:

Physician/ Health Care Provider: **Certified Diabetic Educator:**

Address: Telephone: Fax:

Required by Virginia Law:

I give permission to the school nurse and designated school personnel* who have been trained to perform and carry out the diabetes care tasks for my child as outlined in my child's *Diabetes Medical Management Plan* as ordered by the prescribing health care provider. (Code of Virginia § 22.1-274)
Parent authorization for trained school designees to administer:

INSULIN ☐ Yes ☐ No GLUCAGON ☐ Yes ☐ No

I consent to the release of information contained in the Diabetes Medical Management Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also give permission to contact my endocrinologist and members of the diabetes management team regarding my child's diabetes should the need arise.
*Note: If at any time you would like to have the names of the designated school personnel that have been trained, please contact the school nurse. Names and training records are kept in the school clinic.

Parent / Guardian Name / Signature :	**Date:**
School Nurse Name / Signature:	**Date:**

Patient:_____ Date of Birth: _____ Effective Date: 2016 – 2017 School Year

Medical History	**Parent/Guardian Response (check appropriate boxes and complete blanks)**
Diagnosis information	At what age? Type of diabetes? ☐ Type 1 ☐ Type 2 ☐ Other
Allergies (include foods, medications, etc.)	
How often is child seen by diabetes healthcare provider?	Frequency: Date of last visit:
Nutritional needs	❑ **Gluten Free** ❑ **Other** _____
Snacks	❑ _____ AM _____ PM ❑ Per parent / guardian (i.e. - Before exercise/activity to prevent hypoglycemia, insulin is NOT administered with these snacks.) ❑ In the event of a class party / special activity – per parent/guardian's discretion
Child's most common signs of low blood glucose	❑ trembling ❑ tingling ❑ loss of coordination ❑ dizziness ❑ moist skin/sweating ❑ slurred speech ❑ heart pounding ❑ hunger ❑ confusion ❑ weakness ❑ fatigue ❑ seizure ❑ pale skin ❑ headache ❑ unconsciousness ❑ change in mood or behavior ❑ other _____
Has your child ever experienced an episode of hypoglycemia that required an emergency response?	❑ Yes Date _____ Please explain: _____ ❑ No _____
Frequency of hypoglycemia	❑ once a day ❑ once a week ❑ once a month Indicate date(s) of last episode(s) _____ What time of day is most common for hypoglycemia to occur? _____
Illness/hospitalizations in the last year	Date(s) and describe:
List any other medications currently being taken	

Name of Medication	Dose	When to give	Oral / Injection	Duration

Other concerns and comments	

Supplies to bring to school:	
• Glucose meter, testing strips, lancets, and batteries for the meter • Urine and/or blood ketone test strips and meter • Insulin(s), syringes, and/or insulin pen(s) and supplies • Insulin pump and supplies, including syringes, pen(s), and insulin(s) in case of pump failure	• Carbohydrate-containing snacks, such as whole grain crackers, dried fruit or yogurt • Hypoglycemia treatment supplies; quick-acting glucose and carbohydrate snacks • Water • Glucagon emergency kit • Antiseptic wipes or wet wipes • Other medications

Patient:_____ Date of Birth: _____ Effective Date: 2016 – 2017 School Year

Virginia School Diabetes Medical Management Plan (DMMP) Part 2

Notice to Parent(s) / Guardian(s):
Medication(s) must be brought to school appropriately labeled by the pharmacy or physician/healthcare provider.
In order for schools to safely administer medication in the school setting, the following should be observed:

- A new copy of the DMMP must be completed at the beginning of each school year.
- This form or healthcare provider prescription must be received in order to change diabetes care at school, except for those changes indicated for parent's / guardian's adjustment.
- Trained school personnel may assist child in increasing independence with self-management skills as developmentally appropriate with parental / guardian consent.

Student's Diagnosis:
❑Type 1 Diabetes ❑ Type 2 Diabetes ❑ Other _____

MONITORING	
Blood Glucose Monitoring With meter, lancets, lancing device, and test strips	❑ Yes: ❑ May monitor own blood glucose with supervision ❑ Requires assistance to monitor blood glucose ❑ Independently monitors own blood glucose - Refer to page 8 for permission form
When to check blood glucose	❑ Before meals ❑ For symptoms of hypoglycemia and/or hyperglycemia ❑ Anytime the student does not feel well ❑ Before Physical Education Class ❑ After Physical Education Class ❑ Additional Blood Glucose monitoring may be performed at parent / guardian's request:_____
Continuous Glucose Monitor ❑ Yes - Dex Com / Medtronic ❑ Low limit alarm:_____ ❑ High limit alarm:_____ ❑ Parent/Guardian may adjust alarms	• Always confirm Continuous Glucose Monitor results with finger stick check before taking action on sensor blood glucose level. • If student has symptoms or signs of hypoglycemia, check blood glucose level by finger stick, regardless of Continuous Glucose Monitor reading. • If sensor is dislodged, do NOT discard, student will bring home.
Ketone Checking Urine or Blood	❑ Yes: Anytime the BG >_____ mg/dL two times in a row, at least one hour apart, or when student complains of nausea, vomiting, abdominal pain (See page 7 for hyperglycemia management)

EXERCISE AND SPORTS

A source of fast-acting glucose & glucagon **must** be available in case of hypoglycemia.

Student should **not** exercise for the following reasons:

- His/her blood glucose is < _____ mg/dL (refer to page 6 for hypoglycemia management)
- His/her urine ketones are moderate to large (blood ketones >1.0 mmol/L) immediately prior to exercise (See page 7 for hyperglycemia management)

Student can return to exercise when:

- Blood glucose is > _____ mg/dL OR
- Urine ketones are trace to small (blood ketones < 0.6 mmol/L - 1.0 mmol/L)

MEDICATION – (Other than insulin)

Name	Dose / Route	When to give	Directions
❑ Glucagon	❑ 0.5 mg intramuscular ❑ 1.0 mg intramuscular	• Unconscious • Semi-conscious • Unable to control his/her airway • Unable to swallow AND/OR • Seizing	• Reconstitute per medication instructions • INJECT IMMEDIATELY • Roll student to side-lying position, medication increases vomiting risk • Call 911 • Call parent / guardian
❑ Glucophage (Metformin)	❑ 500 mg by mouth with food ❑ 1000 mg by mouth with food		❑ To be given at school _____AM ❑ To be given at school _____PM
❑ Other			

Healthcare Provider Name / Signature _____Date _____

Patient:_____ Date of Birth: _____ Effective Date: 2016 – 2017 School Year

INSULIN

To be administered subcutaneously by insulin pen; insulin vial and a syringe; or insulin pump
ALWAYS treat hypoglycemia before administration of insulin.

Insulin to be given during school hours:	❑ Yes: ❑ May calculate/give own injections with supervision ❑ Requires assistance to calculate/give injections ❑ Independently calculates/gives own injection - Refer to page 8 for permission form

❑ INTENSIVE

COLUMN A + COLUMN B = TOTAL INSULIN DOSE

COLUMN A (CARBOHYDRATE COVERAGE) = # carbohydrates consumed ÷ carbohydrate ratio
COLUMN B (CORRECTION DOSE) = actual blood glucose – target pre-meal blood glucose ÷ correction factor

- When rounding, only round the total insulin dose
- If uneven, then round to the nearest half or whole unit. (for example, total dose = 1.4 units- then give 1.5 units)
- If physical activity follows meal, then may round down. (for example, total dose = 1.4 units – then give 1.0 units)

INSULIN TYPE	DOSING		
	COLUMN A **Carbohydrate Coverage**	**PLUS**	**COLUMN B** **Correction Dose**
❑ Rapid Acting Insuiln Humalog, Novolog or Apidra ❑ Short Acting Insulin Humulin Regular or Novolin Regular • If carbohydrate intake can be predetermined, insulin should always be given prior to meal/snack • If carbohydrate intake cannot be predetermined, insulin should be given as soon as possible after completion of meal/snack	❑ **BREAKFAST Carbohydrate Ratio:** ___ unit(s) for every _____grams of carbohydrates		❑ **Correction Formula:** **Actual blood glucose - _____ (target) ÷ _____ (correction factor) = _____ units of insulin** **(Add this to carbohydrate coverage, column A)**
	❑ **LUNCH Carbohydrate Ratio:** ___ unit(s) for every _____grams of carbohydrates		**OR**
	❑ **SNACK Carbohydrate Ratio:** ___ unit(s) for every _____grams of carbohydrate		❑ **Follow the correction dose scale below:**
	❑ **PARENT/GUARDIAN may adjust Carbohydrate Ratio from:** ____ unit(s) for every ____grams of carbohydrate **to** ____ unit(s) for every _____grams of carbohydrate		**For blood glucose above TARGET_____** / **Then add this many units of insulin to carbohydrate coverage, column A** _____ / _____ _____ / _____ _____ / _____ _____ / _____ _____ / _____ _____ / _____
	❑ **EXERCISE Carbohydrate Ratio:** Per parent/guardian. Follow the carbohydrate ratio range as indicated in "**Parent/Guardian carbohydrate ratio"**		❑ **This correction may be used to administer insulin for elevated blood glucose if 3 hours or more since last insulin dose.**

❑ CONVENTIONAL

INSULIN TYPE	WHEN	DOSING	
❑ Rapid Acting Insuiln Humalog, Novolog or Apidra ❑ Short Acting Insulin Humulin or Novolin Regular	❑ **PRE meals for _____ grams of carbohydrate**	**Blood Glucose**	**Units of Insulin**
		Less than	

Healthcare Provider Name / Signature _____Date _____

Patient:_____ Date of Birth: _____ Effective Date: 2016 – 2017 School Year

STUDENT ON INSULIN PUMP - Pump Brand/Model: _____

❑**If unable to reach parent/ guardian for pump operation, insulin by injection may be given per DMMP orders.**

Student Skills		
1. Count carbohydrates	❑ Independent	❑ Needs Assistance
2. Bolus for carbohydrates consumed	❑ Independent	❑ Needs Assistance
3. Calculate and administer correction bolus	❑ Independent	❑ Needs Assistance
4. Give injection with syringe or pen, if needed	❑ Independent	❑ Needs Assistance
5. Disconnect pump	❑ Independent	❑ Needs Assistance
6. Reconnect pump at infusion set	❑ Independent	❑ Needs Assistance
7. Access bolus history on pump	❑ Independent	❑ Needs Assistance
8. Prepare reservoir and tubing	❑ Independent	❑ Parent/Guardian
9. Insert infusion set	❑ Independent	❑ Parent/Guardian
10. Use & programming of square/extended/dual/combo bolus features	❑ Independent	❑ Parent/Guardian
11. Use and programming of temporary basal for exercise and illness	❑ Independent	❑ Parent/Guardian
12. Re-program pump settings if needed	❑ Independent	❑ Parent/Guardian
13. Trouble shoot alarms and malfunctions, i.e. change insulin pump batteries	❑ Independent	❑ Parent/Guardian

Additional Times to contact the parent / guardian

- Dislodged infusion set
- Pump malfunction
- Repeated alarms
- Insulin injection given for high blood glucose and / or ketones
- Leakage of insulin at connection to pump or infusion site.
- Soreness, redness or bleeding at infusion site

LONG ACTING INSULIN

To be given during school hours

AND / OR

For extended day, overnight field trips, unplanned disaster / emergency (72 hours)

Insulin Type	**WHEN TO GIVE**	**CURRENT DOSE - To be confirmed prior to extended day or overnight field trip event**	
❑ Humulin NPH OR Novolin NPH ❑ Lantus ❑ Levemir ❑ Other _____	❑ **To be given during school hours** ❑ **To be given for extended day, overnight field trip, unplanned disaster or emergency**	❑ Pre-breakfast dose:	_____ units
		❑ Pre-lunch dose:	_____ units
		❑ Pre-dinner dose:	_____ units
		❑ Bedtime dose:	_____ units

Healthcare Provider Name / Signature _____Date _____

Patient:_____ Date of Birth: _____ Effective Date: 2016 – 2017 School Year

Hypoglycemia Management
(Low Blood Glucose)

If hypoglycemia is suspected, check the blood glucose level with finger check.

Hypoglycemia (Low Blood Glucose): Any blood sugar below _____ mg / dL. Signs may include:

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatigue	Irritable	Crying
Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure

Refer to page 2 for patient specific signs and symptoms

Mild to Moderate Hypoglycemia:

Blood glucose is < _____ mg / dL and student is conscious and able to swallow

1. Immediately give 15 grams fast-acting carbohydrate (example - 3-4 glucose tablets; 4 ounces of regular soda/juice or one small tube glucose/cake gel)

2. Repeat blood glucose check in 15 minutes

3. If blood glucose still <____ mg / dL, then re-treat with 15 grams of fast-acting carbohydrates and repeat blood glucose in 15 minutes.

4. Once blood glucose is > _____ mg / dL
   - If at lunch or snack time, let student eat and cover carbohydrate per orders
   - If not at lunch or snack time, provide student slowly-released carbohydrate snack (example: 3-4 peanut butter crackers, 3-4 cheese crackers or ½ sandwich)
   - Resume normal activity

5. **If unable to raise blood glucose above _____ mg / dL after providing 3 treatments with fast acting glucose**
   - Call parent/guardian
   - If unable to reach parent/guardian, call Health Care Provider
   - If unable to reach Health Care Provider, **call 911**

Severe Hypoglycemia:

If student is unconscious, semi-conscious, unable to control his/her airway, unable to swallow and/or seizing

1. Reconstitute glucagon per medication instructions

2. Administer glucagon intramuscularly

3. Roll student to side-lying position as medication increases risk for vomiting

4. **Call 911** for emergency assistance

5. Call parent/guardian

6. **If on INSULIN PUMP**, Stop insulin pump by any of the following methods:
   - Place pump in "suspend" or "stop mode" (See manufacturer's instructions)
   - Disconnect at site
   - Cut tubing

ALWAYS send pump with EMS to hospital

Healthcare Provider Name / Signature _____Date _____

Patient:_____ Date of Birth: _____ Effective Date: 2016 – 2017 School Year

Hyperglycemia Management
(High Blood Glucose)

If hyperglycemia is suspected, check the blood glucose level with finger check.

Hyperglycemia (High Blood Glucose): Any blood sugar above _____mg / dL. Signs may include:

Extreme thirst	Frequent urination	Blurry Vision	Hunger	Headache
Nausea	Hyperactivity	Irritable	Dizziness	Stomach ache

Refer to page 2 for patient specific signs and symptoms

If hyperglycemia is suspected:

1. Check the blood glucose level with finger check.
2. Encourage student to drink fluids, 8 oz of water when hyperglycemia is present.

If blood glucose is >_____ mg/dL - two times in a row, at least one hour apart, and / or when student complains of nausea, vomiting, or abdominal pain:

1. Check ketones
2. **If unable to check ketones:**
   - Give 8 oz of water and retest blood glucose in 1 hour
   - If student complains of nausea, vomiting, or abdominal pain, call parent to pick up the student
   - If student exhibiting emergency symptoms (see below), **call 911**

If urine ketones are negative to small (blood ketones < 0.6 mmol/L - 1.0 mmol/L)

1. Give 8-16 ounces of water
2. If insulin has not been administered within 3 hours, provide correction insulin according to student's correction factor and target pre-meal blood glucose (see page 4)
3. Return student to his / her classroom
4. Recheck blood glucose and ketones in 3 hours after administering insulin

If urine ketones are moderate to large (blood ketones >1.0 mmol/L)

1. Call parent/guardian
2. If unable to reach parent/guardian, call Health Care Provider
3. Give 8-16 ounces of water
4. If insulin has not been administered within 3 hours, provide correction insulin according to student's correction factor and target pre-meal blood glucose (see page 4)
5. If unable to reach parent/guardian or Health Care Provider, **call 911**
6. **IF ON INSULIN PUMP:**
   Follow the above instructions, plus give insulin correction by insulin vial and syringe and / or insulin pen, not by insulin pump bolus.

HYPERGLYCEMIA EMERGENCY

Call 911 for any of the below symptoms:

Dry mouth	Extreme thirst	Nausea and vomiting	Severe abdominal pain
Heavy breathing or shortness of breath	Chest pain	Increasing sleepiness or lethargy	Depressed level of consciousness

Healthcare Provider Name / Signature _____Date _____

Patient:_____ Date of Birth: _____ Effective Date: 2016 – 2017 School Year

PERMISSION TO BE INDEPENDENT

❑ **Permission for student to independently monitor blood glucose on a school bus, school property, or at a school sponsored activity.**

❑ **Permission for student to independently calculate and administer insulin on a school bus, school property, or at a school sponsored activity.**

- My child has been instructed in and understands his/her diabetes self-management. My child understands that he/she is responsible and accountable for carrying and using his/her medication and equipment and for proper disposal of supplies.
- I hereby give permission for the school to administer the medications as prescribed in the care plan if indicated (ie. student requests assistance or becomes unable to perform self-care).
- I also give permission for the school to contact the student's physician / diabetes management team regarding my child's diabetes care (authorization required if contact is other than the school nurse).
- I understand that the school administration or parent/guardian may revoke permission to possess and self-administer said diabetes medication at any point during the school year if it is determined that my child has abused the privilege of possession and self-administration or if he / she is not safely and effectively self-administering the medication. In addition, my child could be subject to further disciplinary action.

Parent/Guardian Signature_____ Date _____

Student Signature _____ Date _____

❑ I have assessed this student and agree the he / she is capable to be independent as noted above. It is understood that I may revoke permission to possess and self-administer said diabetes medication at any point during the school year if it is determined that he / she has abused the privilege of possession and self-administration or if he / she is not safely and effectively self-administering the medication.

Healthcare Provider Signature _____ Date _____

AUTHORIZATION TO TREAT AND ADMINISTER MEDICATION FOR THE ABOVE VIRGINIA SCHOOL DIABETES MANAGEMENT PLAN

My signature below provides authorization for the Virginia Diabetes Medical Management Plan contained herein. I/We understand that all treatments and procedures may be performed by the school nurse, the student, and/or trained, unlicensed designated school personnel as allowed by school policy or by Emergency Medical Services in the event of loss of consciousness or seizure.
I also give permission for the school and school nurse to contact the health care provider regarding these orders and administration of these medications.

Parent / Guardian Name	Signature	Date
School Representative Name	Signature	Date
Healthcare Provider Name	Signature	Date