Name: _____ DOB: _____Date: _____ School Year: _____ -_____

Virginia Diabetes Medical Management Plan (DMMP)

Adapted from the National Diabetes Education Program DMMP (2016)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Student information

Student's name: _____ Date of birth: _____

Date of diabetes diagnosis:_____☐ Type 1 ☐ Type 2 ☐ Other: _____

School name: _____ School phone number: _____

Grade: _____ Homeroom teacher: _____

School nurse: _____ Phone: _____

Contact information

Parent/guardian 1: _____

Address: _____

Telephone: Home: _____ Work: _____Cell: _____

Email address: _____

Parent/guardian 2: _____

Address: _____

Telephone: Home: _____ Work: _____Cell: _____

Email address: _____

Student's physician / health care provider: _____

Address: _____

Telephone: _____ Emergency Number: _____

Email Address: _____

Other emergency contacts:

Name: _____ Relationship: _____

Telephone: Home: _____ Work: _____Cell: _____

Name: _____ DOB: _____Date: _____ School Year: _____ -_____

Checking blood glucose

Target range of blood glucose: ❑ Before Meal _____ - _____ mg / dL ❑Other _____

Check blood glucose level: ☐ Before breakfast ❑ _____ Hours after breakfast

❑ Before lunch ☐ _____ Hours after lunch ☐ _____Hours after correction dose

☐ Before PE ☐ After PE ☐ Before dismissal ❑ As needed for signs/symptoms of illness

❑ As needed for signs/symptoms of high / low blood glucose ☐ Other: _____

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires a school nurse or trained diabetes personnel to check blood glucose

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

Continuous Glucose Monitoring (CGM) ☐ Yes ☐ No Brand/model: _____

Alarms set for: ❑ Severe Low: _____ ❑ Low: _____ ❑ High: _____

Predictive alarm: ❑ Low: _____ ❑ High: _____ ❑ Rate of change: Low: _____ ❑ High: _____

Threshold suspend setting: _____

Additional information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level.
- If the student 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 any medical adhesive or tape the parent / guardian has provided.
- If the CGM becomes dislodged, remove, and return everything to the parents/guardian. Do not throw anything away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-care CGM Skills	Independent?	
The student is able to troubleshoot alarms and malfunctions.	☐ Yes	☐ No
The student is able to respond to HIGH alarm.	☐ Yes	☐ No
The student is able to respond to LOW alarm.	☐ Yes	☐ No
The student is able to adjust alarms.	☐ Yes	☐ No
The student is able to calibrate the CGM.	☐ Yes	☐ No
The student is able to respond when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ Yes	☐ No
The student should be escorted to the nurse if the CGM alarms	☐ High	☐ Low
Other instructions for the school health team:		

Name: _____ DOB: _____Date: _____ School Year: _____ -_____

Hypoglycemia (Low Blood Glucose)

<u>Hypoglycemia</u>: Any blood glucose below _____ mg / dL checked by blood glucose meter.

Student's usual symptoms of hypoglycemia (circled):

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

Mild to Moderate Hypoglycemia: Student is exhibiting symptoms of hypoglycemia AND blood glucose level is less than _____ mg/dL
1. Give a quick acting glucose product equal to 15 grams fast-acting carbohydrate such as: glucose tablets, juice, glucose gel, gummies, skittles, starbursts
2. Recheck blood glucose in 15 minutes
3. If blood glucose level is < _____, repeat treatment with 15 grams of fast-acting carbohydrates.
4. **Additional Treatment:**

Severe Hypoglycemia: Student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement)
1. Position the student on his or her side to prevent choking
2. Administer glucagon Dose: ☐ 1 mg ☐ 0.5 mg ❑ Other _____ Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM) Site: ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: _____
3. **Call 911** (Emergency Medical Services) • AND the student's parents / guardians. • AND the health care provider.
4. **If on INSULIN PUMP**, <u>Stop insulin pump</u> 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

Name: _____ DOB: _____Date: _____ School Year: _____ -_____

Hyperglycemia (High Blood Glucose)

Hyperglycemia: Any blood glucose above _____ mg/dL checked by blood glucose meter.

Student's usual symptoms of hyperglycemia (circled):

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

Insulin Correction Dose

For blood glucose greater than _____mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders, page 5).
Notify parents/guardians if blood glucose is over _____ mg/dL.
For insulin pump users: see **Additional Information for Student with Insulin Pump.**

Ketones

If blood glucose is above ____ mg/ dL , two times in a row, at least one hour apart and/or when student complains of nausea, vomiting or abdominal pain, check for ketones.

☐ Urine for ketones OR ☐ Blood for ketones

Give ____ounces of water
Allow unrestricted access to the bathroom

If urine ketones are negative to small OR blood ketones < 0.6 mmol/L - 1.0 mmol/L:
1. If insulin has not been administered within ____ hours, provide correction insulin according to student's correction factor and target pre-meal blood glucose (refer to page 5)
2. Return student to his / her classroom
3. Recheck blood glucose and ketones in ____ hours after administering insulin

If urine ketones are moderate to large OR blood ketones >1.0 mmol/L:
1. Do NOT allow student to participate in exercise
2. Call parent / guardian, If unable to reach parent / guardian call health care provider
3. If insulin has not been administered within ____ hours, provide correction insulin according to student's correction factor and target blood glucose. (refer page 5)
4. **IF ON INSULIN PUMP:** See **Additional Information for Student with Insulin Pump**

HYPERGLYCEMIA EMERGENCY
When large ketones are associated with the following symptoms Call 911

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

Insulin therapy

Insulin delivery device: ❑ Insulin pen ❑ Insulin syringe ❑ Insulin pump (refer to page 6)
Type of Insulin therapy at school: ❑Adjustable(basal-bolus) insulin ❑Fixed insulin therapy ❑ None

Adjustable (Basal-Bolus) Insulin Therapy

Insulin Type: Apidra ; Novolog; or Humalog

Carbohydrate Coverage/ Insulin-to-carbohydrate ratio:

- ❑ ***Breakfast:*** ____ unit of insulin per_____ gm of carbohydrate
- ❑ ***Lunch:*** _____ unit of insulin per_____ gm of carbohydrate
- ❑ ***Snack:*** _____ unit of insulin per_____ gm of carbohydrate
- ❑ ***Dinner:*** _____ unit of insulin per_____ gm of carbohydrate

Carbohydrate Dose Calculation Example
$\frac{\textit{Total Grams of Carbohydrate to Be Eaten}}{\textit{Insulin-to-Carbohydrate Ratio}}$ = _____ *Units of Insulin*

❑ **Correction Dose:**

May be used to administer insulin for elevated blood glucose if greater than _____hours since last insulin dose:
Blood glucose correction factor (insulin sensitivity factor) = _____
Target blood glucose = _____mg/dL

Correction Dose Calculation Example
$\frac{\textit{Current Blood Glucose} - \textit{Target Blood Glucose}}{\textit{Correction Factor}}$ = _____ *Units of Insulin*

❑ **Correction dose scale** (use instead of calculation above to determine insulin correction dose):

May be used to administer insulin for elevated blood glucose if greater than _____ hours since last insulin 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: _____

Name: _____ DOB: _____Date: _____ School Year: _____ -_____

Insulin therapy (continued)

Fixed Insulin Therapy Name of insulin: _____

☐ _____ Units of insulin given pre-breakfast daily
☐ _____ Units of insulin given pre-lunch daily
☐ _____ Units of insulin given pre-snack daily
☐ Other: _____

Parents/Guardians Authorization to Adjust Insulin Dose		
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.	☐ Yes	☐ No

Student's Self-Care Insulin Administration Skills
☐ Independently calculates / gives own injections. ☐ May calculate / give own injections with supervision. ☐ Requires a school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision. ☐ Requires a school nurse or trained diabetes personnel to calculate dose and give the injection.

Additional Information for Students with Insulin Pumps

Brand / model of pump: _____ Insulin Type: Apidra ; Novolog; or Humalog
Basal rates during school: Time: _____ Basal rate: _____ 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) :_____
☐ If Blood glucose greater than _____mg/dL that has not decreased within _____hours after correction and / or if student has moderate to large ketones. 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.

Adjustments for Physical Activity Using Insulin Pump

May disconnect from pump for sports activities: ☐ Yes, for _____ hours	☐ No	☐ Per parent
Set temporary basal rate: ☐ Yes, ____% temporary basal for ___ hours	☐ No	☐ Per parent
Suspend pump use: ☐ Yes, for _____ hours	☐ No	☐ Per parent

Name: _____ DOB: _____Date: _____ School Year: _____ -_____

Student's Self-care Pump Skills	Independent?	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alarms and malfunctions	☐ Yes	☐ No

Other diabetes medications

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

Meal plan ❑ Not applicable

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'/Guardians' discretion ☐ Student discretion

Student's self-care nutrition skills:
☐ Independently counts carbohydrates
☐ May count carbohydrates with supervision
☐ Requires school nurse/trained diabetes personnel to count carbohydrates

Physical activity and sports - A quick-acting source of glucose must be available at the site of physical education activities and sports. Examples include glucose tabs, sugar-containing juice.
Student 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, student 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 ketones are moderate to large / blood ketones are > 1.0 mmol/L.
(See **Administer Insulin** for additional information for students on insulin pumps.)

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: _____

This Diabetes Medical Management Plan has been approved by:

Student's Physician / Health Care Provider Name	**Date:**
Student's Physician / Health Care Provider Signature	**Date:**

Name: _____ DOB: _____Date: _____ School Year: _____ -_____

Authorization to Treat and Administer Medication in the School Setting as Required by Virginia Law

I give permission to the school nurse and designated unlicensed trained school personnel who have been trained to perform and carry out the diabetes care tasks for the student, as outlined in the student's Diabetes Medical Management Plan, and as allowed by school policy, state law or emergency services (Code of Virginia § 22.1-274, §54.1-2901(A)(26)).

I give permission to the student to carry with him/her and use supplies, including a reasonable and appropriate short-term supply of carbohydrates, an insulin pump, and equipment for immediate treatment of high and low blood glucose levels, and to self-check his/her own blood glucose levels on a school bus, on school property, and at a school-sponsored activity (Code of Virginia §22.1-274.01:1).

My signature below provides authorization for a local school board employee who is a registered nurse or licensed practical nurse and who has been trained in the administration of insulin, including the use and insertion of insulin pumps, that they may assist the student with the insertion or reinsertion of the insulin pump or any of its parts (Code of Virginia §22.1-274.01:1).

Parent/Guardian Name / Signature:	**Date:**
School Representative:	**Date;**

Consent to Release Information:

I also consent to the release of information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my student and who may need to know this information to maintain my student's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my student's diabetes health care providers.

Parent/Guardian Name / Signature:	**Date:**
School Representative:	**Date;**

Suggested Supplies to Bring to School

• Glucose meter, testing strips, lancets, and batteries for the meter • Insulin(s), syringes, and/or insulin pen(s) and supplies • Insulin pump and supplies in case of failure: Reservoirs, sets, prep wipes, pump batteries / charging	• Treatment for low blood sugar (see page 3) • Protein containing snacks: such as granola bars • Water • Glucagon emergency kit • Antiseptic wipes or wet wipes • Urine and/or blood ketone test strips and meter • Other medication