

Name: _____ DOB: _____ Date: _____ School Year: _____ - _____

Virginia Diabetes Medical Management Plan (DMMP) Adapted from the National Diabetes Education Program DMMP

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:	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> 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 Contact	Relationship to Student:
Telephone: : Home: _____	Work: _____ Cell: _____
Email address:	

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 4)
- Protein containing snacks: such as granola bars
- Emergency Medication Supplies
- Antiseptic wipes or wet wipes
- Water
- Urine and/or blood ketone test strips and meter
- Other medication

Name: _____ DOB: _____ Date: _____ School Year: _____ - _____

Student's Self-care Skills

Blood Glucose:

- ☐ Independently checks own blood glucose
- ☐ May check blood glucose with supervision
- ☐ Requires school nurse or trained diabetes personnel to check blood glucose
- ☐ Uses a smartphone or other monitoring technology to track blood glucose values

Insulin Administration:

- ☐ Independently calculates / gives own injections
- ☐ May calculate / give own injections with direct supervision to confirm glucose and insulin dose
- ☐ Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision
- ☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection

Nutrition:

- ☐ Independently counts carbohydrates
- ☐ May count carbohydrates with supervision
- ☐ Requires school nurse/trained diabetes personnel to count carbohydrates
- ☐ Parents'/Guardians' discretion for **special event/party food**
- ☐ Student discretion for **special event/party food**

Parents / Guardians Authorization to Adjust Insulin Dose

Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parents/guardians are authorized to increase or decrease insulin-to carbohydrate ratio from: ____ unit(s) for every _____ grams of carbohydrate to ____ unit(s) for every _____ grams of carbohydrate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Checking Blood Glucose

Target Blood Glucose: ☐ Before Meal _____ - _____ mg / dL ☐ Other _____ - _____ mg/dL

<input type="checkbox"/> Before breakfast	<input type="checkbox"/> Before lunch	<input type="checkbox"/> Before PE	<input type="checkbox"/> As needed for signs/symptoms of illness
<input type="checkbox"/> Before Dismissal	<input type="checkbox"/> Other times requested by parent/guardian: _____	<input type="checkbox"/> After PE	<input type="checkbox"/> As needed for signs/symptoms of high/low blood glucose

Name: _____ DOB: _____ Date: _____ School Year: _____ - _____

Continuous Glucose Monitoring (CGM)

☐ Yes ☐ No Brand/model: _____

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

Predictive alarm: ☐ Rapid Fall: _____ ☐ Rapid Rise: _____

Student/School Personnel may use CGM for insulin calculation

if glucose reading between _____ - _____ mg/dL ☐ Yes ☐ No

Student/School Personnel may use CGM for hypoglycemia and hyperglycemia management ☐ Yes ☐ No
(Refer to Hypoglycemia and Hyperglycemia section of this document once confirmed)

Additional information for student with 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. Check glucose by finger stick until CGM is replaced / reinserted by parent/guardian or student.
- Refer to the manufacturer's instructions on how to use the student's device.
- Refer to VDC's CGM Position Statement (<https://virginiadiabetes.org/diabetes-in-schools/>)

Student's Self-care CGM Skills	Independent?	
The student is able to troubleshoot alarms and alerts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student is able to adjust alarms.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student is able to calibrate the CGM.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student is able to respond when the CGM indicates a rapid trending rise or fall in the blood glucose level.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
School nurse or trained personnel notified if CGM alarms	<input type="checkbox"/> High	<input type="checkbox"/> Low
Other instructions for the school health team:		

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, juice, glucose gel, gummies, skittles, starbursts, cake icing.

Student should eat:

Carbohydrate Amount	Before	Every 30 minutes	Every 60 minutes	After activity	Per Parent
15 grams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30 grams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

AND / OR if urine ketones are moderate to large / blood ketones are > 1.0 mmol/L

For insulin pump users: see "Additional Information for Student with Insulin Pump", page 7".

Name: _____ DOB: _____ Date: _____ School Year: _____ - _____

Hypoglycemia (Low Blood Glucose)

Hypoglycemia: Any blood glucose below _____ mg / dL checked by blood glucose meter or CGM.

Student's usual symptoms of hypoglycemia (circled):

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

Mild to Moderate Hypoglycemia:

Student is exhibiting symptoms of hypoglycemia AND / OR blood glucose level is less than _____ mg/dL

1. Give a fast-acting glucose product equal to _____ **grams fast-acting carbohydrate** such as:
glucose tablets, juice, glucose gel, gummies, skittles, starbursts, cake icing
2. Recheck blood glucose in 15 minutes
3. If blood glucose level is less than _____, repeat treatment with _____ grams of fast-acting carbohydrates.
4. Consider providing a carbohydrate/protein snack once glucose returns to normal range, as per parent/guardian.
5. **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 emergency medication.

Injectable Route (Glucagon, Glucagen, Gvoke)	OR	Nasal route (Baqsimi)
Dose: <input type="checkbox"/> 1 mg <input type="checkbox"/> 0.5 mg		Dose: <input type="checkbox"/> 3 mg (Baqsimi brand)
Route: <input type="checkbox"/> Subcutaneous (SC) <input type="checkbox"/> Intramuscular (IM)		Route: <input type="checkbox"/> Intranasal (IN Baqsimi brand)
Site: <input type="checkbox"/> Buttocks <input type="checkbox"/> Arm <input type="checkbox"/> Thigh <input type="checkbox"/> Lower Abdomen		Site: <input type="checkbox"/> Nose (Baqsimi brand only)

3. **Call 911** (Emergency Medical Services)

- AND the student's parents / guardians.
- AND the health care provider.

4. **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 pump at site

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 or CGM.

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, refer to page 6).

Recheck blood glucose in _____ hours

Notify parents/guardians if blood glucose is over _____ mg/dL.

For insulin pump users: see "Additional Information for Student with Insulin Pump", refer to page 7".

Ketones

Check ☐ Urine for ketones OR ☐ Blood for 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,

Give _____ ounces of water and allow unrestricted access to the bathroom

If urine ketones are negative to small OR blood ketones < 0.6 - 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 6)
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 to page 6)
4. **IF ON INSULIN PUMP:** See "Additional Information for Student with Insulin Pump", refer to page 7

HYPERGLYCEMIA EMERGENCY

Presence of ketones 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

Name: _____ DOB: _____ Date: _____ School Year: _____ - _____

Insulin therapy ☐ Insulin pen or Syringe ☐ Insulin pump (refer to page 7)

☐ Adjustable Bolus Insulin Therapy ☐ Fixed Insulin Therapy ☐ Long-Acting Insulin Therapy

☐ **Adjustable Bolus Insulin Therapy:**

Apidra (glulisine), Novolog (aspart), Humalog (lispro), Fiasp (aspart), Admelog (lispro). Brands are interchangeable.

When to give insulin:	INSULIN to CARBOHYDRATE +	INSULIN to CARBOHYDRATE Only	Correction only
	Correction		
Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snack AM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snack PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

☐ **INSULIN to CARBOHYDRATE Dose Calculation**

Total Grams of Carbohydrate to Be Eaten
"B" Insulin-to-Carbohydrate Ratio

X "A" Units of Insulin = _____ Units of Insulin

	"A" Units of Insulin	"B" Insulin-to-Carbohydrate Ratio
<input type="checkbox"/> Breakfast	_____ unit of insulin	Per _____ gm of carbohydrate
<input type="checkbox"/> Lunch	_____ unit of insulin	Per _____ gm of carbohydrate
<input type="checkbox"/> Snack AM	_____ unit of insulin	Per _____ gm of carbohydrate
<input type="checkbox"/> Snack PM	_____ unit of insulin	Per _____ gm of carbohydrate

☐ **CORRECTION Dose Calculation (For Elevated blood sugar and ≥ 3 hours since last insulin dose)**

Current Blood Glucose – "C" Target Blood Glucose
"D" Correction Factor

X "E" Units of insulin = _____ Units of Insulin

"C" Target Blood Glucose	"D" Correction Factor	"E" Units of insulin
_____	_____	<input type="checkbox"/> 0.5 unit
		<input type="checkbox"/> 1.0 unit

OR

☐ **CORRECTION Dose Scale ((For Elevated blood sugar and ≥ 3 hours since last insulin dose. Use instead of calculation above to determine insulin correction dose)**

Blood Glucose	Insulin Dose
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units

☐ **Fixed Insulin Therapy**

Name of insulin: _____

☐ _____ Units of insulin given pre-breakfast daily

☐ _____ Units of insulin given pre-snack daily

☐ _____ Units of insulin given pre-lunch daily

☐ Other: _____

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☐ **Long-Acting Insulin Therapy**

Name of Insulin (Circle): Lantus Basaglar Levemir Tresiba (u100/u200) Toujeo (u300)

- ☐ To be given during school hours: ☐ Pre-breakfast dose: _____ units
☐ Pre-lunch dose: _____ units
☐ Pre-dinner dose: _____ units

☐ **Other Diabetes Medications:**

- ☐ Name: _____ Dose: _____ Route: _____ Times given: _____
☐ Name: _____ Dose: _____ Route: _____ Times given: _____
☐ Name: _____ Dose: _____ Route: _____ Times given: _____

Disaster Plan/Extended Day Field Trips - 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 doses): _____

Additional Information for Students with Insulin Pumps

Brand / model of pump: _____

- ☐ Refer to attached pump settings provided by parent/guardian or healthcare provider
☐ Other pump instructions: *Medtronic 530G, 630G, 670G, or TSlim X2 with Basal IQ may be enabled with the hypoglycemia automatic insulin suspend (stopped for up to 2 hours)*
☐ Medtronic 670G and TSlim X2 Control IQ pump utilizes advanced hybrid closed loop technology to adjust insulin delivery to help prevent highs and lows, while still allowing the user to manually bolus for meals.

Hyperglycemia Management:

- ☐ 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 using insulin dosing prescribed on page 6
☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen using insulin dosing prescribed on page 6

Adjustments for Physical Activity Using Insulin Pump

May disconnect from pump for sports activities: <input type="checkbox"/> Yes, for _____ hours	<input type="checkbox"/> No
Set temporary basal rate: <input type="checkbox"/> Yes, _____ % temporary basal for _____ hours	<input type="checkbox"/> No
Suspend pump use: <input type="checkbox"/> Yes, for _____ hours	<input type="checkbox"/> No
Temp Target (specific to Medtronic): 150 mg/dL <input type="checkbox"/> Yes, for _____ hours	<input type="checkbox"/> No
Exercise Activity use (specific to TSlim X2 with Control IQ): <input type="checkbox"/> Yes	<input type="checkbox"/> No

Student's Self-care Pump Skills	Independent?	
Administers carbohydrate and correction bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes batteries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnects and reconnects pump to infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepares reservoir, pod, and/or tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inserts infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoots alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name: _____ DOB: _____ Date: _____ School Year: _____ - _____

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

This Diabetes Medical Management Plan has been approved by the undersigned Health Care Provider.

It further authorizes schools to treat and administer medication as indicated by this plan and required by Virginia Law.

Providers:

My signature below provides authorization for the Virginia Diabetes Medical Management Plan contained herein. I understand that all treatments and procedures may be performed by the student, the school nurse, unlicensed trained designated school personnel, as allowed by school policy, state law or emergency services as outlined in this plan. 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 the student as outlined in the student's Diabetes Medical Management Plan as ordered by the prescribing health care provider (Code of Virginia § 22.1-274).

Parents:

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.

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).

SELF-CARRY

Parent authorization for student to self-administer insulin	<input type="checkbox"/> YES <input type="checkbox"/> NO
Parent authorization for student to self-monitor blood glucose	<input type="checkbox"/> YES <input type="checkbox"/> NO
Prescriber authorization for student to self-administer insulin	<input type="checkbox"/> YES <input type="checkbox"/> NO
Prescriber authorization for student to self-monitor blood glucose	<input type="checkbox"/> YES <input type="checkbox"/> NO

***For self-carry: Provider and Parent must both agree to the statements above per** (Code of Virginia §22.1-274.01:1)

Parent / Guardian Name / Signature:	Date:
School representative Name / Signature:	Date:
Student's Physician / Health Care Provider Name / Signature:	Date:

References:

- https://www.virginiadiabetes.org/content.aspx?page_id=22&club_id=947464&module_id=327026
- <http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/GuidanceDocumentMDiabetesMedicalManagePlanHCPOF.pdf>
- <http://www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/legal-protections/state-laws-and-policies.html>
- <http://www.diabetes.org/dmmp>
- A 504 Plan is separate from a DMMP form. See <http://www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/legal-protections/section-504.html> or <http://www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/written-care-plans/section-504-plan.html>
- VDC's CGM Position Statement (<https://virginiadiabetes.org/diabetes-in-schools/>)

Name: _____ DOB: _____ Date: _____ School Year: _____

Virginia Diabetes Medical Management Plan (DMMP) – Supplement

☐ **Adjustable Bolus Insulin Therapy:**

Apidra (glulisine), Novolog (aspart), Humalog (lispro), Fiasp (aspart), Admelog (lispro). Brands are interchangeable.

When to give insulin:	INSULIN to CARBOHYDRATE +	INSULIN to CARBOHYDRATE Only	Correction only
	Correction		
Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snack AM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snack PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

☐ **INSULIN to CARBOHYDRATE Dose Calculation**

Total Grams of Carbohydrate to Be Eaten X "A" Units of Insulin = _____ Units of Insulin
 "B" Insulin-to-Carbohydrate Ratio

	"A" Units of Insulin	"B" Insulin-to-Carbohydrate Ratio
<input type="checkbox"/> Breakfast	_____ unit of insulin	Per _____ gm of carbohydrate
<input type="checkbox"/> Lunch	_____ unit of insulin	Per _____ gm of carbohydrate
<input type="checkbox"/> Snack AM	_____ unit of insulin	Per _____ gm of carbohydrate
<input type="checkbox"/> Snack PM	_____ unit of insulin	Per _____ gm of carbohydrate

☐ **CORRECTION Dose Calculation (For Elevated blood sugar and ≥ 3 hours since last insulin dose)**

Current Blood Glucose – "C" Target Blood Glucose X "E" Units of insulin = _____ Units of Insulin
 "D" Correction Factor

"C" Target Blood Glucose	"D" Correction Factor	"E" Units of insulin
_____	_____	<input type="checkbox"/> 0.5 unit
		<input type="checkbox"/> 1.0 unit

OR

☐ **CORRECTION Dose Scale ((For Elevated blood sugar and ≥ 3 hours since last insulin dose. Use instead of calculation above to determine insulin correction dose)**

Blood Glucose	Insulin Dose
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units

☐ Fixed Insulin dose change:

☐ Long-Acting Insulin dose change:

☐ Other Changes:

This Diabetes Medical Management Plan has been approved by:

Parent / Guardian Name / Signature:	Date:
School representative Name / Signature:	Date:
Student's Physician / Health Care Provider Name / Signature:	Date: