

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

Virginia Diabetes Medical Management Plan (DMMP) Adapted from the National Diabetes Education Program DMMP (2019)

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

| | |
|--|--|
| <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Treatment for low blood sugar (see page 3) • Protein containing snacks: such as granola bars • Glucagon emergency kit • Antiseptic wipes or wet wipes • Water • Urine and/or blood ketone test strips and meter • Other medication |
|--|--|

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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"/> _____ Hours after breakfast | <input type="checkbox"/> _____ Hours after lunch | <input type="checkbox"/> After PE | <input type="checkbox"/> As needed for signs/symptoms of high/low blood glucose |
| <input type="checkbox"/> _____ Hours after correction dose | <input type="checkbox"/> Before dismissal | <input type="checkbox"/> Other: _____ | |

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.
- 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 alerts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The student is able to respond to HIGH alarm. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The student is able to respond to LOW alarm. | <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 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**, Stop insulin pump by any of the following methods:
 - Place pump in "suspend" or "stop mode" (See manufacturer's instructions)
 - Disconnect/remove 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 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, page 5).

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

For insulin pump users: see "**Additional Information for Student with Insulin Pump**", page 6".

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 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**", page 6

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)

Type of Insulin therapy at school:

- Adjustable Bolus insulin Fixed insulin therapy Long-Acting Insulin None

Adjustable Bolus Insulin Therapy:

Apidra, Novolog, Humalog, Fiasp, Admelog (brands interchangeable).

When to give insulin:

| <input type="checkbox"/> INSULIN to CARBOHYDRATE Dose Calculation | | | | |
|--|---|---|-----------------------------|----------------------------------|
| <u>Total Grams of Carbohydrate to Be Eaten</u> | | X | <u>"B" Units of Insulin</u> | = <u> </u> Units of Insulin |
| <u>"A" Insulin-to-Carbohydrate Ratio</u> | | | | |
| | INSULIN to CARBOHYDRATE Dose Calculation only | INSULIN to CARBOHYDRATE Dose Calculation + correction | Correction dose only | None |
| <i>Breakfast</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Lunch</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Snack AM</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Snack PM</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <u>"A" Insulin-to-Carbohydrate Ratio</u> | <u>"B" Units of Insulin</u> | |
| <input type="checkbox"/> | <i>Breakfast</i> | per _____ gm of carbohydrate | _____ unit of insulin | |
| <input type="checkbox"/> | <i>Lunch</i> | per _____ gm of carbohydrate | _____ unit of insulin | |
| <input type="checkbox"/> | <i>Snack</i> | per _____ gm of carbohydrate | _____ unit of insulin | |
| <input type="checkbox"/> | <i>Dinner</i> | per _____ gm of carbohydrate | _____ unit of insulin | |

| <input type="checkbox"/> CORRECTION Dose Calculation | | |
|---|------------------------------|--|
| <u>Current Blood Glucose – "C" Target Blood Glucose</u> | | X |
| <u>"D" Correction Factor</u> | | <u>"E" Units of insulin</u> |
| | | = <u> </u> Units of Insulin |
| <u>"C" Target Blood Glucose</u> | <u>"D" Correction Factor</u> | <u>"E" Units of insulin</u> |
| _____ | _____ | <input type="checkbox"/> 0.5 unit <input type="checkbox"/> 1.0 unit |

| <input type="checkbox"/> CORRECTION Dose Scale | |
|---|------------------|
| Blood Glucose | Insulin Dose |
| _____ to _____ mg/dL | give _____ units |
| _____ to _____ mg/dL | give _____ units |
| _____ to _____ mg/dL | give _____ units |
| _____ to _____ mg/dL | give _____ units |

| <input type="checkbox"/> Fixed Insulin Therapy | |
|---|---|
| Name of insulin: _____ | |
| <input type="checkbox"/> _____ Units of insulin given pre-breakfast daily | <input type="checkbox"/> _____ Units of insulin given pre-lunch daily |
| <input type="checkbox"/> _____ Units of insulin given pre-snack daily | <input type="checkbox"/> Other: _____ |

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* YES NO
- Parent authorization for student to self-monitor blood glucose* YES NO
- Prescriber authorization for student to self-administer insulin* YES NO
- Prescriber authorization for student to self-monitor blood glucose* YES 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: |