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:	☐ 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 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 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

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 s**pecial 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.	☐ Yes	☐ 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	☐ Yes	☐ No
Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.	☐ Yes	☐ No

Checking Blood Glucose

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

☐ Before breakfast	❑ Before lunch	☐ Before PE	❑ As needed for signs/symptoms of illness
❑ _____ Hours after breakfast	☐ _____ Hours after lunch	☐ After PE	❑ As needed for signs/symptoms of high/low blood glucose
☐ _____Hours after correction dose	☐ Before dismissal	☐ 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	☐ 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
School nurse or trained personnel notified if CGM alarms	☐ High	☐ 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	☐	☐	☐	☐	☐
30 grams	☐	☐	☐	☐	☐

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:

❑ INSULIN to CARBOHYDRATE Dose Calculation

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

	INSULIN to CARBOHYDRATE Dose Calculation only	INSULIN to CARBOHYDRATE Dose Calculation + correction	Correction dose only	None
Breakfast	❑	❑	❑	❑
Lunch	❑	❑	❑	❑
Snack AM	❑	❑	❑	❑
Snack PM	❑	❑	❑	❑

		"A" Insulin-to-Carbohydrate Ratio	***"B" Units of Insulin***
❑	***Breakfast***	per_____ gm of carbohydrate	_____ unit of insulin
❑	***Lunch***	per_____ gm of carbohydrate	_____ unit of insulin
❑	***Snack***	per_____ gm of carbohydrate	_____ unit of insulin
❑	***Dinner***	per_____ gm of carbohydrate	_____ unit of insulin

❑ CORRECTION Dose Calculation

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***
_____	_____	❑ 0.5 unit ❑ 1.0 unit

❑ 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

❑ 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: _____

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

❑ 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: _____ Manufacturer's phone number: _____
Basal rates during school: ❑_____
☐ Refer to attached pump settings
Other pump instructions: _____

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: ☐ Yes, for _____ hours	☐ No
Set temporary basal rate: ☐ Yes, ____% temporary basal for ___ hours	☐ No
Suspend pump use: ☐ Yes, for _____ hours	☐ No
Temp Target (specific to Medtronic): 150 mg/dL ☐ Yes, for _____ hours	☐ No

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

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: