**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.

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| --- | --- |
| **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: |

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| **Hypoglycemia (Low Blood Glucose)****Hypoglycemia: 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 |
| 1. Recheck blood glucose in 15 minutes
 |
| 1. If blood glucose level is < \_\_\_\_\_, repeat treatment with 15 grams of fast-acting carbohydrates.
 |
| 1. **Additional Treatment:**
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|  |
| **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
 |
| 1. Administer glucagon Dose: 🞎 1 mg 🞎 0.5 mg ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Route: 🞎 Subcutaneous (SC) 🞎 Intramuscular (IM) Site: 🞎 Buttocks 🞎 Arm 🞎 Thigh 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **Call 911** (Emergency Medical Services)
* AND the student’s parents / guardians.
* AND the health care provider.
 |
| 1. **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 |

**Hyperglycemia (High Blood Glucose)**

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| **Hyperglycemia: Any blood glucose above ­­­­\_\_\_\_\_\_ mg/dL checked by blood glucose meter.** **Student’s usual symptoms of hyperglycemia (circled):**

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| --- | --- | --- | --- | --- |
| 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 ketonesGive \_\_\_\_ounces of waterAllow 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)
 |
| 1. Return student to his / her classroom
 |
| 1. 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
 |
| 1. Call parent / guardian, If unable to reach parent / guardian call health care provider
 |
| 1. If insulin has not been administered within \_\_\_\_ hours, provide correction insulin according to student’s correction factor and target blood glucose. (refer page 5)
 |
| 1. **IF ON INSULIN PUMP:** See **Additional Information for Student with Insulin Pump**
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|  |
| **HYPERGLYCEMIA EMERGENCY** **When large ketones are associated with the following symptoms Call 911**  |
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| Chest pain | Nausea and vomiting | Severe abdominal pain |
| Heavy breathing or shortness of breath | Increasing sleepiness or lethargy | Depressed level of consciousness |

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| **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

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| **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** |
| ***Total Grams of Carbohydrate to Be Eaten*****=** \_\_\_\_\_ ***Units of Insulin******Insulin-to-Carbohydrate Ratio*** |

**❑ 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

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| **Correction Dose Calculation Example** |  |
| ***Current Blood Glucose − Target Blood Glucose*****=** \_\_\_\_\_ ***Units of Insulin******Correction Factor*** |

**❑ 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 \_\_\_\_ unitsBlood 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: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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 |

|  |  |
| --- | --- |
| **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:** |

**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
 |