

Institution Name and Address:

**DIABETES MEDICAL MANAGEMENT PLAN
CONVENTIONAL THERAPY or TYPE 2**

Page 1 of 3

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

Part 2: Virginia Diabetes Medical Management Plan (DMMP)

To be completed by physician/provider.

Notice to Parents: Medication(s) **MUST** be brought to school by the PARENT/GUARDIAN in a container that is appropriately labeled by the pharmacy or physician/practitioner.

In order for schools to safely administer medication during school hours, the following guidelines should be observed:

- A new copy of the DMMP must be completed at the beginning of each school year. This form, an Authorization for Medication Administration form, or MD prescription must be received in order to change diabetes care at school during the school year.

Student Name (Last, First, MI)		Student's Date of Birth	
School		Student's Grade:	Home Phone
Parent Name		Work/Cell Phone	
Home Address		City	State, Zip code
Student's Diagnosis: DIABETES: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other		Today's Date	

MONITORING			
BLOOD GLUCOSE (BG) MONITORING with meter, lancets, lancing device, and test strips	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Before meals <input type="checkbox"/> For symptoms of hypo/hyperglycemia & anytime the student does not feel well <input type="checkbox"/> Before PE/Activity <input type="checkbox"/> After PE/Activity <input type="checkbox"/> Prior to dismissal <input type="checkbox"/> Additional BG monitoring may be performed at parent's request	
	<input type="checkbox"/> Student requires supervision <input type="checkbox"/> To be performed by school personnel <input type="checkbox"/> Student is independent <input type="checkbox"/> Permission to self-carry		
CONTINUOUS GLUCOSE MONITORING (CGM) Brand/Model: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Alarms set for: Low: _____ (mg/dL) High: _____ (mg/dL)	Always confirm CGM results with finger stick check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check finger stick blood glucose level regardless of CGM.	
<input type="checkbox"/> URINE KETONE TESTING <input type="checkbox"/> BLOOD KETONE TESTING	Anytime the BG > _____ mg/dL or when student complains of nausea, vomiting, abdominal pain. See page 3 for further instructions under hyperglycemia management.		
NAME OF MEDICATION	DOSE/ROUTE	TIME	
<input type="checkbox"/> GLUCAGON - INJECTABLE	<input type="checkbox"/> 0.5 mg subq/IM <input type="checkbox"/> 1.0 mg subq/IM	Immediately for severe hypoglycemia: unconscious, semi-conscious (unable to control his/her airway or unable to swallow), or seizing	
ORAL MEDICATIONS	DOSAGE	TIME	POSSIBLE SIDE EFFECTS
<input type="checkbox"/> Glucophage® (Metformin) <input type="checkbox"/> to be administered at school	_____ mg po	_____ AM or PM	Nausea/vomiting, diarrhea
<input type="checkbox"/> Other: _____ <input type="checkbox"/> to be administered at school			Clear liquids
<input type="checkbox"/> Additional Instructions:			

Specific duration of order:	Physician/Provider Signature:	Provider Printed Name:	Office Phone: _____
SCHOOL YEAR			Office Fax: _____
			Emergency # _____

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Page 2 of 3

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

SCHOOL YEAR **DIABETES SCHOOL CARE PLAN**
CONVENTIONAL THERAPY OR TYPE 2 DIABETES

Student: _____

Effective date: _____

INSULIN			
Insulin to be given during school hours: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Student can administer insulin if supervised <input type="checkbox"/> Student can administer his/her own insulin <input type="checkbox"/> Student can not administer insulin	
Insulin Types: <input type="checkbox"/> Rapid-acting Insulin Type: _____ [®] <input type="checkbox"/> Short-acting Insulin Type: Regular <input type="checkbox"/> Intermediate-acting Insulin Type: NPH <input type="checkbox"/> may mix with rapid or short-acting insulin <input type="checkbox"/> Long-acting Insulin Type: _____ [®] units at _____ am or pm <input type="checkbox"/> may mix with rapid-acting insulin <i>(all doses to be administered subcutaneously)</i>		<input type="checkbox"/> Meal Plan: <input type="checkbox"/> according to the following distribution: Breakfast: _____ grams AM Snack: _____ grams Lunch: _____ grams PM Snack: _____ grams <input type="checkbox"/> Insulin:CHO Ratio: 1 unit for every _____ grams of CHO <input type="checkbox"/> decrease by 1 unit if pre-lunch reading is less than 80 mg/dL or if strenuous exercise is anticipated.	
<input type="checkbox"/> Pre-breakfast dose: Regular _____ units Humalog [®] or Novolog [®] or Apidra [®] _____ units NPH _____ units <input type="checkbox"/> Pre-lunch dose: Regular _____ units Humalog [®] or Novolog [®] or Apidra [®] _____ units NPH _____ units <input type="checkbox"/> Pre-dinner dose: Regular _____ units Humalog [®] or Novolog [®] or Apidra [®] _____ units NPH _____ units			
<input type="checkbox"/> Sliding scale to be administered at _____ (times) If blood glucose Units of rapid-acting Insulin subq _____ give _____ _____ give _____ _____ give _____ _____ give _____ _____ give _____ _____ give _____		<input type="checkbox"/> Insulin Sensitivity (Correction Factor) to be administered at _____ (times) <ul style="list-style-type: none"> the predicted drop in blood glucose concentration after administration of 1 unit of regular or rapid-acting insulin usually expressed as "1 unit for every _____ mg/dl blood glucose is > target" If uneven, then round to the nearest half or whole unit (May use clinical discretion; if physical activity follows meal, then may round down) Sensitivity: _____ Target: _____	
<input type="checkbox"/> Other Instructions:			

Snacks

- Children using NPH insulin usually require snacks without additional insulin coverage (please, adhere to CHO amounts ordered above).
- Scheduled snacks may be required prior to or after exercise in order to prevent hypoglycemia. Insulin is not administered with these snacks.

Before Exercise After Exercise
- Foods may be eaten at unscheduled times. Insulin may be ordered for these snacks in order to prevent post-meal hyperglycemia (see above).
- Snack time insulin = # carbohydrates consumed/CHO Ratio.
- Never provide insulin coverage for carbohydrate/glucose being used to treat hypoglycemia.

Exercise and Sports

- In general, there are no restrictions on activity unless specified.
- A student should not exercise if his/her blood glucose is <100 mg/dL or > 300 mg/dL and ketones are positive.
- A source of fast-acting glucose & glucagon (if ordered) should be available in case of hypoglycemia.

Specific duration of order:	Physician/Provider Signature: _____	Provider Printed Name: _____	Office Phone: _____
SCHOOL YEAR			Office Fax: _____
			Emergency # _____

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Page 3 of 3

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SCHOOL YEAR _____ DIABETES SCHOOL CARE PLAN _____

Student: _____

Effective date: _____

Hypoglycemia (Low Blood Glucose)

Hypoglycemia is defined as a blood glucose \leq _____ mg/dL

Signs of hypoglycemia:

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatigue	Fighting	Crying
Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure

- If hypoglycemia is suspected, check the blood glucose level.

Hypoglycemia Management (Low Blood Glucose)	Severe Hypoglycemia: If student unconscious, semi-conscious (unable to control his/her airway or unable to swallow), or seizing, administer glucagon. <ul style="list-style-type: none"> • Place student in the "recovery position." • If glucagon is administered, call 911 for emergency assistance, and call Parents/Legal Guardian.
	Mild or Moderate Hypoglycemia: If conscious & able to swallow, immediately give 15 gram fast-acting glucose: <ul style="list-style-type: none"> • 3-4 glucose tablets or • 6 Life Saver® Candies or • 4 ounces of regular soda/juice or • 1 small tube Glucose/Cake gel
	Repeat BG check in 15 minutes <ul style="list-style-type: none"> • If BG still low, then re-treat with 15 gram CHO • If BG in acceptable range and at lunch or snack time, let student eat and cover CHO per orders • If BG in acceptable range and not lunch or snack time, provide student slowly-released CHO snack (3-4 peanut butter or cheese crackers or ½ sandwich)
	If unable to raise the BG > 70 mg/dL despite fast-acting glucose sources, call _____

Hyperglycemia (High Blood Glucose)

Signs of hyperglycemia:

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

- If hyperglycemia is suspected, check the blood glucose level.

Hyperglycemia Management (High Blood Glucose)	If BG > 300 mg/dL, or when child complains of nausea, vomiting, and/or abdominal pain, ask the student to check his/her urine for ketones
	<ul style="list-style-type: none"> • If urine ketones are trace or negative (blood ketones 0 - 1.0 mmol/L), give 8-16 ounces of sugar-free fluid (water), return to classroom. • If correction insulin has not been administered within 3 hours, provide correction insulin according to student's Correction Factor and Target pre-meal BG • Recheck BG and ketones 2 hours after administering insulin
	<ul style="list-style-type: none"> • If urine ketones are moderate/large (blood ketones > 1.0 mmol/L), give 8-16 ounces of sugar-free fluid (water) and call _____ for instructions concerning insulin administration. • Contact the Parent/Legal Guardian. • Recheck BG and ketones 2 hours after administering insulin

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations. I also give permission for the school to contact the health care provider regarding these orders and administration of these medications.

School plan ordered by:	Physician/Provider Signature:	Provider Printed Name:	Date:
Acknowledged and received by:	Parent/Legal Guardian:		Date:
Acknowledged and received by:	School Representative:		Date: