**Institution Name and Address:**

**DIABETES MEDICAL MANAGEMENT PLAN**
**INTENSIVE THERAPY**



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 regulations 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:** ☐ **Type 1** ☐ **Type 2** ☐ **Other** | Today's Date | |

| **MONITORING** | | |
|---|---|---|
| **BLOOD GLUCOSE (BG) MONITORING** with meter, lancets, lancing device, and test strips | ☐ Yes ☐ No<br>☐ Student requires supervision<br>☐ To be performed by school personnel<br>☐ Student is independent<br>☐ Permission to self-carry | ☐ Before meals<br>☐ For symptoms of hypo/hyperglycemia & anytime the student does not feel well<br>☐ Before PE/Activity<br>☐ After PE/Activity<br>☐ Prior to dismissal<br>☐ Additional BG monitoring may be performed at parent's request |
| **CONTINUOUS GLUCOSE MONITORING (CGM)**<br>**Brand/Model:** _____ | ☐ Yes ☐ No<br>Alarms set for: Low:_____ (mg/dL)<br>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. |
| ☐ **URINE KETONE TESTING**<br>☐ **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** | |
|---|---|---|---|---|
| **GLUCAGON** - INJECTABLE | ☐ 0.5 mg subq/IM<br>☐ 1.0 mg subq/IM | | Immediately for severe hypoglycemia: unconscious, semi-conscious (unable to control his/her airway or unable to swallow), or seizing | |
| | **DOSAGE** | **TIME** | **POSSIBLE SIDE EFFECTS** | **TREATMENT OF SIDE EFFECTS** |
| ☐ Glucophage® (Metformin)<br>☐ to be administered at school | _____ mg po | _____ AM or PM | Nausea/vomiting, diarrhea | Clear liquids |
| ☐ Other: _____®<br>☐ to be administered at school | | | | |

**Additional Instructions**:

| Specific duration of order:<br>**2011-2012**<br>**SCHOOL YEAR** | Physician/Provider Signature: Provider Printed Name: | Office Phone: _____<br>Office Fax: _____<br>**Emergency #** _____ |
|---|---|---|

Institution Form #

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## SCHOOL YEAR 2011-2012 DIABETES SCHOOL CARE PLAN

**Student:** _____

**Intensive Therapy/Multiple Daily Injections** **Effective date:** _____

### Definitions

| Insulin-to-Carbohydrate Ratio (CHO Ratio) | Insulin Sensitivity (Correction Factor) | Target Blood Glucose |
|---|---|---|
| • the amount of insulin necessary to prevent hyperglycemia after ingestion of a specified amount of carbohydrate<br>• usually expressed as "1 unit for every ____ grams of carbohydrate" | • the predicted drop in blood glucose concentration after administration of 1 unit of regular or rapid-acting insulin<br>• usually expressed as "1 unit for every ____mg/dl blood glucose is > target" | • a specific blood glucose value used to determine the correction dose of insulin administered with a meal |

## INSULIN

Insulin to be given during school hours: ☐ Yes ☐ No

☐ May calculate/give own injections with supervision
☐ Requires assistance to calculate/give injections
☐ Independently calculates/gives own injection

☐ Rapid-acting Insulin Type: _____®
*(all doses to be administered subcutaneously)*

☐ _____® _____units at _____am or pm
☐ may mix with rapid-acting insulin
*(all doses to be administered subcutaneously)*

**Timing of Insulin Dose:**
Rapid-acting Insulin should always be given prior to
☐ meals ☐ snacks
if CHO intake can be predetermined.
➢ If CHO intake cannot be predetermined insulin should be given no more than 30 minutes after completion of meal/snack.
➢ Treat hypoglycemia before administration of meal or snack insulin.

**CALCULATING INSULIN DOSES**: According to CHO ratio and Insulin Sensitivity/Correction Factor (if needed) - the student requires meal time coverage with rapid-acting insulin based on the amount of carbohydrates in the meal and may require additional insulin to correct blood glucose to the desired range according to the following formula:

**Insulin Dose = [(Actual BG – Target pre-meal BG) divided by Insulin Sensitivity] + [# carbohydrates consumed/CHO Ratio]**

- Fractional amounts of insulin from correction and carbohydrate calculation, when added together, may yield an even amount of insulin
- If uneven, then round to the nearest **half or whole unit** (May use clinical discretion; if physical activity follows meal, then may round down).

**Target pre-meal BG: _____ mg/dL**

**Insulin Sensitivity/Correction Factor:**
**__ unit for every _____ > target**

**CHO Ratio:**

☐ Parent has permission to adjust CHO ratio in a range from 1:_____ to 1:_____

**Exercise/PE CHO Ratio: _____ ☐ Not Applicable**
- Less insulin may be required with meals prior to physical activity in order to prevent hypoglycemia. If so, the Exercise/PE CHO Ratio should be used instead of the CHO Ratio.

☐ Correction insulin to be administered for elevated blood glucose if 3 hours or more after last insulin dose

### Snacks

- In general, children with diabetes managed using Intensive Therapy/MDI do not require snacks.
- 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 specifically noted.
- A student should not exercise if his/her blood glucose is < 70 mg/dL or > 300 mg/dL (with positive ketones) immediately prior to exercise or until hypoglycemia/hyperglycemia is resolved.
- A source of fast-acting glucose & glucagon should be available in case of hypoglycemia.

| Specific duration of order: **2011-2012 SCHOOL YEAR** | Physician/Provider Signature: Provider Printed Name: | Office Phone: _____<br>Office Fax: _____<br>**Emergency #** _____ |
|---|---|---|

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## SCHOOL YEAR DIABETES SCHOOL CARE PLAN

**Student:** _____
**Effective date:** _____

### Hypoglycemia (Low Blood Glucose)

Hypoglycemia is defined as a blood glucose **<**_____ mg/dL

Signs of hypoglycemia:

| | | | | |
|---|---|---|---|---|
| Hunger | Sweating | Shakiness | Paleness | Dizziness |
| Confusion | Loss of coordination | Fatique | 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.**<br>• Place student in the "recovery position."<br>• 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 grams fast-acting glucose:**<br>• 3-4 glucose tablets or<br>• 6 Life Saver® Candies or<br>• 4 ounces of regular soda/juice or<br>• 1 small tube Glucose/Cake gel |
| | **Repeat BG check in 15 minutes**<br>• If BG still low, then re-treat with 15 gram CHO<br>• If BG in acceptable range and at lunch or snack time, let student eat and cover CHO per orders<br>• If BG in acceptable range and not lunch or snack time, provide student slowly-released CHO snack (Example: 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 > ___ mg/dL, or when child complains of nausea, vomiting, and/or abdominal pain, ask the student to check his/her urine for ketones** |
| | • If urine ketones are trace to small (blood ketones 0 - 1.0 mmol/L), give 8-16 ounces of sugar-free fluid (water), return to classroom<br>• If correction insulin has not been administered within 3 hours, provide correction insulin according to student's Correction Factor and Target pre-meal BG<br>• Recheck BG and ketones ____ hours after administering insulin |
| | • 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.<br>• Contact the Parent/Legal Guardian.<br>• Recheck BG and ketones _____ 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: |