

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ School Year: \_\_\_\_\_ - \_\_\_\_\_

## Virginia Diabetes Medical Management Plan (DMMP)

### Adapted from the National Diabetes Education Program DMMP

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.

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### 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: \_\_\_\_\_

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### 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: \_\_\_\_\_

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### 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.

Student's Self-care CGM Skills	Independent?	
The student is able to troubleshoot alarms and malfunctions.	<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
The student should be escorted to the nurse if the CGM alarms	<input type="checkbox"/> High	<input type="checkbox"/> 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
2. Recheck blood glucose in 15 minutes
3. If blood glucose level is < \_\_\_\_\_, repeat treatment with 15 grams of fast-acting carbohydrates.
4. **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 at site
  - Cut tubing

**ALWAYS** send pump with EMS to hospital

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## Hyperglycemia (High Blood Glucose)

**Hyperglycemia:** Any blood glucose above \_\_\_\_\_ mg/dL checked by blood glucose meter.

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

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 ketones

Give \_\_\_\_\_ ounces of water

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

**When large ketones are 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

## 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

#### 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
$\frac{\text{Total Grams of Carbohydrate to Be Eaten}}{\text{Insulin-to-Carbohydrate Ratio}} = \text{Units of Insulin}$

#### 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

Correction Dose Calculation Example
$\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Correction Factor}} = \text{Units of Insulin}$

#### 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 \_\_\_\_\_ units

Blood 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: \_\_\_\_\_

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

Parents/Guardians Authorization to Adjust Insulin Dose		
Parents/guardians authorization should be obtained before administering a correction dose.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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

Student's Self-Care Insulin Administration Skills
<input type="checkbox"/> Independently calculates / gives own injections.
<input type="checkbox"/> May calculate / give own injections with supervision.
<input type="checkbox"/> Requires a school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.
<input type="checkbox"/> 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: \_\_\_\_\_

Other pump instructions: \_\_\_\_\_ Type of infusion set / 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: <input type="checkbox"/> Yes, for _____ hours	<input type="checkbox"/> No	<input type="checkbox"/> Per parent
Set temporary basal rate: <input type="checkbox"/> Yes, _____% temporary basal for _____ hours	<input type="checkbox"/> No	<input type="checkbox"/> Per parent
Suspend pump use: <input type="checkbox"/> Yes, for _____ hours	<input type="checkbox"/> No	<input type="checkbox"/> Per parent

Student's Self-care Pump Skills	Independent?	
Counts carbohydrates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates correct amount of insulin for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Administers correction bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes batteries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnects pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnects pump to infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepares reservoir, pod, and/or tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inserts infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoots alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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**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 _____
<b>Other times to give snacks and content/amount:</b>		
<b>Instructions for when food is provided to the class</b> (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:

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 or if urine ketones are moderate to large / blood ketones are > 1.0 mmol/L.

(See "**Adjustments for Physical Activity Using Insulin Pump**", page 6 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: \_\_\_\_\_

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### 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).

Parent authorization for student to self-administer insulin       YES  NO

Parent authorization for student to self-monitor blood glucose  YES  NO

Parent / Guardian Name / Signature :	Date:
School representative Name / Signature:	Date:
Student’s Physician / Health Care Provider Name / Signature:	Date:



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**Suggested Supplies to Bring to School**

<ul style="list-style-type: none"><li>• Glucose meter, testing strips, lancets, and batteries for the meter</li><li>• Insulin(s), syringes, and/or insulin pen(s) and supplies</li><li>• Insulin pump and supplies in case of failure: Reservoirs, sets, prep wipes, pump batteries / charging</li></ul>	<ul style="list-style-type: none"><li>• Treatment for low blood sugar (see page 3)</li><li>• Protein containing snacks: such as granola bars</li><li>• Glucagon emergency kit</li><li>• Antiseptic wipes or wet wipes</li><li>• Water</li><li>• Urine and/or blood ketone test strips and meter</li><li>• Other medication</li></ul>
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