Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN
CONVENTIONAL THERAPY or TYPE 2

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

MONITORING		
BLOOD GLUCOSE (BG) MONITORING with meter, lancets, lancing device, and test strips	☐ Yes ☐ No ☐ Student requires supervision ☐ To be performed by school personnel ☐ Student is independent ☐ Permission to self-carry	☐ Before meals ☐ For symptoms of hypo/hyperglycemia & anytime the student does not feel well ☐ Before PE/Activity ☐ After PE/Activity ☐ Prior to dismissal ☐ Additional BG monitoring may be performed at parent's request
CONTINUOUS GLUCOSE MONITORING (CGM) **Brand/Model:** ______________	☐ Yes ☐ 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.
☐ **URINE KETONE TESTING** ☐ **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 ☐ 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**	**TREATMENT SIDE EFFECTS**
☐ Glucophage® (Metformin) ☐ to be administered at school	_____ mg po	_____ AM or PM	Nausea/vomiting, diarrhea	Clear liquids
☐ Other: ® ☐ to be administered at school				
☐ Additional Instructions:				

Specific duration of order: **2009-2010 SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: ______________ Office Fax: ______________ **Emergency # ____________**

Institution Form #

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CONVENTIONAL THERAPY or TYPE 2

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

SCHOOL YEAR 2009-2010 DIABETES SCHOOL CARE PLAN
CONVENTIONAL THERAPY OR TYPE 2 DIABETES

Student: ______________
Effective date: __________

INSULIN

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

☐ Student can administer insulin if supervised
☐ Student can administer his/her own insulin
☐ Student can not administer insulin

Insulin Types:

☐ Rapid-acting Insulin Type: ____________®
☐ Short-acting Insulin Type: **Regular**

☐ Intermediate-acting Insulin Type: **NPH**
☐ may mix with rapid or short-acting insulin

☐ Long-acting Insulin Type: ____________® _______units at _______am or pm
☐ may mix with rapid-acting insulin

(all doses to be administered subcutaneously)

☐ **Meal Plan:**

☐ according to the following distribution:

Breakfast: _______ grams
AM Snack: _______ grams
Lunch: _______ grams
PM Snack: _______ grams

☐ Insulin:CHO Ratio: 1 unit for every _______ grams of CHO
☐ decrease by 1 unit if pre-lunch reading is less than 80 mg/dL or if strenuous exercise if anticipated.

☐ Pre-breakfast dose: Regular ______ units Humalog® or Novolog® or Apidra® ______ units NPH ______ units
☐ Pre-lunch dose: Regular _______ units Humalog® or Novolog® or Apidra® _______ units NPH _______ units
☐ Pre-dinner dose: Regular _______ units Humalog® or Novolog® or Apidra® _______ units NPH _______ units

☐ **Sliding scale to be administered at _______ (times)**

If blood glucose		Units of rapid-acting Insulin subq
____________________	give	_______________________
____________________	give	_______________________
____________________	give	_______________________
____________________	give	_______________________
____________________	give	_______________________
____________________	give	_______________________

☐ **Insulin Sensitivity (Correction Factor) to be administered at _______ (times)**

- 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: _______

☐ 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: **2009-2010 SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: _______________ Office Fax: ________________ **Emergency # ____________**

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CONVENTIONAL THERAPY or TYPE 2

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

SCHOOL YEAR 2009-2010 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. • 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: • 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 • 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
	• 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
	• 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:

Institution Form #