Virginia Diabetes Medical Management Plan (DMMP)
Adapted from the National Diabetes Education Program DMMP (2019)

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

<table>
<thead>
<tr>
<th>Student’s name:</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of diabetes diagnosis:</td>
<td>□ Type 1 □ Type 2 □ Other:</td>
</tr>
<tr>
<td>School name:</td>
<td>School phone number:</td>
</tr>
<tr>
<td>Grade:</td>
<td>Homeroom teacher:</td>
</tr>
<tr>
<td>School nurse:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

### Contact information

**Parent/guardian 1**

<table>
<thead>
<tr>
<th>Address:</th>
<th>Telephone:</th>
<th>Home:</th>
<th>Work:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email address:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Parent/guardian 2**

<table>
<thead>
<tr>
<th>Address:</th>
<th>Telephone:</th>
<th>Home:</th>
<th>Work:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email address:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Student’s physician / health care provider**

<table>
<thead>
<tr>
<th>Address:</th>
<th>Telephone:</th>
<th>Emergency Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Emergency Contact**

<table>
<thead>
<tr>
<th>Relationship to Student:</th>
<th>Telephone:</th>
<th>Home:</th>
<th>Work:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email address:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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
- Glucagon emergency kit
- Antiseptic wipes or wet wipes
- Water
- Urine and/or blood ketone test strips and meter
- Other medication
Student’s Self-care Skills

Blood Glucose:
- ☐ Independently checks own blood glucose
- ☐ May check blood glucose with supervision
- ☐ Requires school nurse or trained diabetes personnel to check blood glucose
- ☐ Uses a smartphone or other monitoring technology to track blood glucose values

Insulin Administration:
- ☐ Independently calculates / gives own injections
- ☐ May calculate / give own injections with direct supervision to confirm glucose and insulin dose
- ☐ Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision
- ☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection

Nutrition:
- ☐ Independently counts carbohydrates
- ☐ May count carbohydrates with supervision
- ☐ Requires school nurse/trained diabetes personnel to count carbohydrates
- ☐ Parents'/Guardians’ discretion for special event/party food
- ☐ Student discretion for special event/party food

Parents / Guardians Authorization to Adjust Insulin Dose

<table>
<thead>
<tr>
<th>Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- ______ units of insulin.</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
</table>

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 | ☐ Yes | ☐ No |

Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- ______ units of insulin. | ☐ Yes | ☐ No |

Checking Blood Glucose

Target Blood Glucose: ☐ Before Meal _____ - _____ mg / dL ☐ Other _____ - _____mg/dL

| ☐ Before breakfast | ☐ Before lunch | ☐ Before PE | ☐ As needed for signs/symptoms of illness |
| ☐ _____ Hours after breakfast | ☐ _____ Hours after lunch | ☐ After PE | ☐ As needed for signs/symptoms of high/low blood glucose |
| ☐ _____ Hours after correction dose | ☐ Before dismissal | ☐ Other: ___________________________ |
Continuous Glucose Monitoring (CGM)

- Yes  □ No  Brand/model: ___________________

- Alarms set for:  □ Severe Low: ______  □ Low: ______  □ High: ______

- Predictive alarm:  □ Rapid Fall: ______  □ Rapid Rise: ______

Student/School Personnel may use CGM for insulin calculation

- if glucose reading between _____ - _____mg/dL  □ Yes  □ No

Student/School Personnel may use CGM for hypoglycemia and hyperglycemia management  □ Yes  □ No

(Refer to Hypoglycemia and Hyperglycemia section of this document once confirmed)

Additional information for student with 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. Check glucose by finger stick until CGM is replaced / reinserted by parent/guardian.
- Refer to the manufacturer’s instructions on how to use the student’s device.

<table>
<thead>
<tr>
<th>Student’s Self-care CGM Skills</th>
<th>Independent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student is able to troubleshoot alarms and alerts</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>The student is able to respond to HIGH alarm.</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>The student is able to respond to LOW alarm.</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>The student is able to adjust alarms.</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>The student is able to calibrate the CGM.</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>The student is able to respond when the CGM indicates a rapid trending rise or fall in the blood glucose level.</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>School nurse or trained personnel notified if CGM alarms</td>
<td>□ High □ Low</td>
</tr>
<tr>
<td>Other instructions for the school health team:</td>
<td></td>
</tr>
</tbody>
</table>
**Hypoglycemia (Low Blood Glucose)**

**Hypoglycemia:** Any blood glucose below ____ mg / dL checked by blood glucose meter or CGM.

**Student’s usual symptoms of hypoglycemia (circled):**

<table>
<thead>
<tr>
<th>Hunger</th>
<th>Sweating</th>
<th>Shakiness</th>
<th>Paleness</th>
<th>Dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>Loss of coordination</td>
<td>Fatigue</td>
<td>Irritable/Anger</td>
<td>Crying</td>
</tr>
<tr>
<td>Headache</td>
<td>Inability to concentrate</td>
<td>Hypoglycemia Unawareness</td>
<td>Passing-out</td>
<td>Seizure</td>
</tr>
</tbody>
</table>

**Mild to Moderate Hypoglycemia:**  
Student is exhibiting symptoms of hypoglycemia AND / OR blood glucose level is less than ____ mg/dL

1. Give a fast-acting glucose product equal to _____ grams fast-acting carbohydrate such as: glucose tablets, juice, glucose gel, gummies, skittles, starbursts, cake icing

2. Recheck blood glucose in 15 minutes

3. If blood glucose level is less than ____, repeat treatment with _____ grams of fast-acting carbohydrates.

4. Consider providing a carbohydrate/protein snack once glucose returns to normal range, as per parent/guardian.

5. **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/remove at site/cut tubing  

**ALWAYS** send pump with EMS to hospital
Hyperglycemia (High Blood Glucose)

Hyperglycemia: Any blood glucose above ______ mg/dL checked by blood glucose meter or CGM.

Student’s usual symptoms of hyperglycemia (circled):

<table>
<thead>
<tr>
<th>Extreme thirst</th>
<th>Frequent urination</th>
<th>Blurry Vision</th>
<th>Hunger</th>
<th>Headache</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>Hyperactivity</td>
<td>Irritable</td>
<td>Dizziness</td>
<td>Stomach ache</td>
</tr>
</tbody>
</table>

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

Check □ Urine for ketones OR □ Blood for 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,
Give ____ounces of water and 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**

Presence of ketones associated with the following symptoms Call 911

<table>
<thead>
<tr>
<th>Chest pain</th>
<th>Nausea and vomiting</th>
<th>Severe abdominal pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavy breathing or shortness of breath</td>
<td>Increasing sleepiness or lethargy</td>
<td>Depressed level of consciousness</td>
</tr>
</tbody>
</table>
## Insulin therapy
- Insulin pen or Syringe
- Insulin pump *(refer to page 7)*

### Type of Insulin therapy at school:
- Adjustable Bolus insulin
- Fixed insulin therapy
- Long-Acting Insulin
- None

- **Adjustable Bolus Insulin Therapy:**
  Apidra, Novolog, Humalog, Fiasp, Admelog (brands interchangeable).

### When to give insulin:

### INSULIN to CARBOHYDRATE Dose Calculation

<table>
<thead>
<tr>
<th>Total Grams of Carbohydrate to Be Eaten</th>
<th>“A” Insulin-to-Carbohydrate Ratio</th>
<th>INSULIN to CARBOHYDRATE Dose Calculation only</th>
<th>INSULIN to CARBOHYDRATE Dose Calculation + correction</th>
<th>Correction dose only</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Snack AM</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Snack PM</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

- **“A” Insulin-to-Carbohydrate Ratio:**
  - Breakfast per _____ gm of carbohydrate _________ unit of insulin
  - Lunch per _____ gm of carbohydrate _________ unit of insulin
  - Snack per _____ gm of carbohydrate _________ unit of insulin
  - Dinner per _____ gm of carbohydrate _________ unit of insulin

### CORRECTION Dose Calculation

<table>
<thead>
<tr>
<th>Current Blood Glucose – “C” Target Blood Glucose</th>
<th>“D” Correction Factor</th>
<th>“E” Units of insulin</th>
</tr>
</thead>
<tbody>
<tr>
<td>“C” Target Blood Glucose</td>
<td>“D” Correction Factor</td>
<td></td>
</tr>
</tbody>
</table>

- **“D” Correction Factor:**
  - 0.5 unit
  - 1.0 unit

### CORRECTION Dose Scale

<table>
<thead>
<tr>
<th>Blood Glucose</th>
<th>Insulin Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ to _____ mg/dL</td>
<td>give _____ units</td>
</tr>
<tr>
<td>_____ to _____ mg/dL</td>
<td>give _____ units</td>
</tr>
<tr>
<td>_____ to _____ mg/dL</td>
<td>give _____ units</td>
</tr>
</tbody>
</table>

### 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: ___________________________
Long-Acting Insulin Therapy

Name of Insulin (Circle): Lantus  Basaglar  Levemir  Tresiba (u100/u200)  Toujeo (u300)

☐ To be given during school hours:
   ☐ Pre-breakfast dose: _______units
   ☐ Pre-lunch dose: _______units
   ☐ Pre-dinner dose: _______units

Other diabetes medications:

☐ Name: ___________ Dose: _______ Route: _______ Times given: _______
☐ Name: ___________ Dose: _______ Route: _______ Times given: _______
☐ Name: ___________ Dose: _______ Route: _______ Times given: _______

Disaster Plan/Extended Day Field Trips - 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 doses):

Additional Information for Students with Insulin Pumps

Brand / model of pump: _________________________ Manufacturer’s phone number: __________________

Basal rates during school:

☐ Refer to attached pump settings
Other pump instructions: _________________________

Hyperglycemia Management:

☐ 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 using insulin dosing prescribed on page 6
☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen using insulin dosing prescribed on page 6

Adjustments for Physical Activity Using Insulin Pump

May disconnect from pump for sports activities: ☐ Yes, for ______ hours ☐ No
Set temporary basal rate: ☐ Yes, _____% temporary basal for ___ hours ☐ No
Suspend pump use: ☐ Yes, for _____ hours ☐ No
Temp Target (specific to Medtronic): 150 mg/dL ☐ Yes, for _____ hours ☐ No

Student’s Self-care Pump Skills

<table>
<thead>
<tr>
<th></th>
<th>Independent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counts carbohydrates</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Calculates correct amount of insulin for carbohydrates consumed</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Administers correction bolus</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Calculates and sets basal profiles</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Calculates and sets temporary basal rate</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Changes batteries</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Disconnects pump</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Reconnects pump to infusion set</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Prepares reservoir, pod, and/or tubing</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Inserts infusion set</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Troubleshoots alarms and malfunctions</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>
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 □
- **Prescriber authorization for student to self-administer insulin**
  - YES □ NO □
- **Prescriber authorization for student to self-monitor blood glucose**
  - YES □ NO □

*For self-carry: Provider and Parent must both agree to the statements above per (Code of Virginia §22.1-274.01:1)

<table>
<thead>
<tr>
<th>Parent / Guardian Name / Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School representative Name / Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Student’s Physician / Health Care Provider Name / Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>