JHCD-R-F3 Rev. 2010

Virginia School Diabetes Medical Management Forms

Student	School		Effective Date	
Date of Birth	Grade	Homeroom Tea	cher	
nstructions:				
 Part 1- Contact Informa and returned to school nu ►Includes: Parent authorization Law). 	ırse (prior to beginni	ing of each school y	ear or upon diagnosis).	· ·
 Part 2*- Diabetes Media Intensive Therapy or Con Please note that physician auth 	ventional Therapy/T	ype 2 version of DN by trained school design	MP.	•
Management Plan or a separat 3. Part 3*- Insulin Pump			n/provider, diabetes e	educator, and
parent/guardian collabora 4. Part 4- Permission to S physician/provider, school	ite to complete appr Self-Carry and Self-	opriate portions if yo -Administer Diabet	our child wears an insul es Care To be con	in pump. opleted by the
administer insulin and/or Virginia Diabetes Coun accepted accommodation	perform blood gluco cil School Diabete ns and references a	se checks in the cla s Care Practice and applicable to all stu	ssroom. d Protocol providents with diabetes.	es guidelines, This document is
available from your school nurs Other Diabetes Medical Managem				
_	•			
Return completed forms to th	e school nurse as q	uickly as possible.	Thank you for your coo	peration.
School nurse		Phone	Date	
Part 1: Contact Infor	mation and Dia	betes Medical	History	Page 1 of 2
To be completed by Parent/G	Guardian:		-	
Parent/Guardian #1:				
Address:				
			Cell:	
Parent/Guardian #2:				
Address:				
			Cell:	
Other emergency contact: _				
5 ,				
Address:				
			Relationship: Cell:	
Telephone-Home:		Work:	Relationship: Cell:	
Telephone-Home:	es:	Work:	Relationship: Cell:	
Telephone-Home: Physician managing diabet Address:	es:	Work:	Relationship: Cell:	

Page 2 of 2 Student:

Medical History	Parent/Guardian Response (check appropriate boxes and complete blanks)				
Diagnosis information	At what age?	pe of diabetes?			
How often is child seen by diabetes physician?	Frequency: Da	ate of last visit:			
Nutritional needs	◆ Snacks □AM □PM □ □ Only in case of low blood glucose □ Student may determine if CHO cour □ In the event of a class party may eat the indicated in medical orders) □ student able to determine whether to eat □ replace with parent supplied treat □ may NOT eat the treat ◆ Other	e treat (include insulin coverage if			
Child's most common signs of low blood glucose	□ trembling □ tingling □ dizziness □ moist skin/sweating □ heart pounding □ hunger □ weakness □ fatigue □ pale skin □ headache □ change in mood or behavior □ other	 □ loss of coordination □ slurred speech □ confusion □ seizure □ unconsciousness 			
How often does child experience low blood glucose and how severe?	Mild/Moderate □ once a day □ once a we Indicate date(s) of last mild/moderate episode(s) What time of day is most common for hypoglycemia	a to occur?			
	Severe (i.e. unconscious, unable to swallow, seizu Include date(s) of recent episode(s)	re, or needed Glucagon)			
Episode(s) of ketoacidosis	Include date(s) of recent episode(s)				
Field trips	Parent/guardian will accompany child during field tri YES NO Yes, if available				
Serious illness, injuries or hospitalizations this past year	Date(s) and describe				
List any other medications currently being taken					
Allergies (include foods, medications, etc):					
Other concerns and comments					
supervision of the school no Medical Management Plan a	nool nurse and designated school personnel*, who have to perform and carry out the diabetes ca re tasks ordered by the physician. I give permission to the the following diabetes care tasks for my child. (Code c	s as outlined in my child's <i>Diabet</i> es e designated school personnel, who			
Insulin Administration \(\square\)	YES NO Glucagon Administration	☐ YES ☐ NO			
consent to the release of inf adults who have custodial c and safety. I also give pern	vide all supplies to the school n ecessary for the t rea ormation contained in the Diabetes Medical Managemare of my child and who may need to know this information to contact the above named physician and meabetes should the need arise.	ent Plan to staff members and other mation to maintain my child's health			
Parent/Guardian Name		Date			
Parent/Guardian Signature)				
School Nurse's Name		Date			

*Note: If at any time you would like to have the names of the designated school personnel that have been trained, please contact the school nurse. Names and training records are kept in the school clinic.

Virginia School Diabetes Medical Management Forms

Student	School		Effective Date
Date of Birth	Grade	Homeroom Teach	ner
Instructions:			
and returned to school n	urse (prior to beginning	of each school yea	o be completed by parent/guardiar ar or upon diagnosis). sulin and/or glucagon (required by Virginia
Part 2*- Diabetes Med Intensive Therapy or Co	nventional Therapy/Typ thorization for treatment by t	e 2 version of DMN	ent's physician/provider to complete MP. es must be included in the Diabetes Medica
3. Part 3*- Insulin Pum	p Supplement . Ha		provider, diabetes educator, and
 Part 4- Permission to physician/provider, scho administer insulin and/or Virginia Diabetes Cou accepted accommodation 	Self-Carry and Self-Action nurse and the pare perform blood glucose ncil School Diabetes Cons and references app	Iminister Diabetes ent/guardian if you checks in the class care Practice and olicable to all stud	ur child wears an insulin pump. S Care . To be completed by the ur child is going to carry and sel sroom. Protocol provides guidelines ents with diabetes. This document is Services, or the Virginia Diabetes Council.
			as all components are represented.
_	·	_	
Return completed forms to t	he school nurse as quic	kly as possible. T	hank you for your cooperation.
School nurse		Phone	Date
Part 1: Contact Info	mation and Diabe	etes Medical F	History Page 1 of 2
To be completed by Parent/	Guardian:		
Parent/Guardian #1:			
			Cell:
Parent/Guardian #2:			
Telephone-Home:	V	Vork:	Cell:
Other emergency contact:			
			elationship:
			Cell:
Physician managing diabe	etes:		
Main Office #	Fax #	Emer	gency Phone #
Nurse/Diabetes Educator:			Office #
ITUI 30/ DIADELES LUUCALUI.			Office #

Page 2 of 2 Student:

Medical History	Parent/Guardian Response (check appropriate boxes and complete blanks)				
Diagnosis information	At what age?	pe of diabetes?			
How often is child seen by diabetes physician?	Frequency: Da	ate of last visit:			
Nutritional needs	◆ Snacks □AM □PM □ □ Only in case of low blood glucose □ Student may determine if CHO cour □ In the event of a class party may eat the indicated in medical orders) □ student able to determine whether to eat □ replace with parent supplied treat □ may NOT eat the treat ◆ Other	e treat (include insulin coverage if			
Child's most common signs of low blood glucose	□ trembling □ tingling □ dizziness □ moist skin/sweating □ heart pounding □ hunger □ weakness □ fatigue □ pale skin □ headache □ change in mood or behavior □ other	 □ loss of coordination □ slurred speech □ confusion □ seizure □ unconsciousness 			
How often does child experience low blood glucose and how severe?	Mild/Moderate □ once a day □ once a we Indicate date(s) of last mild/moderate episode(s) What time of day is most common for hypoglycemia	a to occur?			
	Severe (i.e. unconscious, unable to swallow, seizu Include date(s) of recent episode(s)	re, or needed Glucagon)			
Episode(s) of ketoacidosis	Include date(s) of recent episode(s)				
Field trips	Parent/guardian will accompany child during field tri YES NO Yes, if available				
Serious illness, injuries or hospitalizations this past year	Date(s) and describe				
List any other medications currently being taken					
Allergies (include foods, medications, etc):					
Other concerns and comments					
supervision of the school no Medical Management Plan a	nool nurse and designated school personnel*, who have to perform and carry out the diabetes ca re tasks ordered by the physician. I give permission to the the following diabetes care tasks for my child. (Code c	s as outlined in my child's <i>Diabet</i> es e designated school personnel, who			
Insulin Administration \(\square\)	YES NO Glucagon Administration	☐ YES ☐ NO			
consent to the release of inf adults who have custodial c and safety. I also give pern	vide all supplies to the school n ecessary for the t rea ormation contained in the Diabetes Medical Managemare of my child and who may need to know this information to contact the above named physician and meabetes should the need arise.	ent Plan to staff members and other mation to maintain my child's health			
Parent/Guardian Name		Date			
Parent/Guardian Signature)				
School Nurse's Name		Date			

*Note: If at any time you would like to have the names of the designated school personnel that have been trained, please contact the school nurse. Names and training records are kept in the school clinic.

Name of Institution

Institution Address

Department DIABETES MEDICAL MANAGEMENT PLAN INTENSIVE THERAPY

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.

<u>Notice to Parents</u>: 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.

School year.						
Student Name (Last, First, MI)	Student's Date of Birth					
School		Student's G	Student's Grade Home Phone		е	
Parent Name	Work/Cell F	Phone				
Home Address	City		State, Zip co	ode		
Student's Diagnosis: DIABETES: Diagnosis:	Today's Da	ite	'			
	MONITO	DINC				
	MONITO	JRING		e meals		
BLOOD GLUCOSE (BG) MONITORING with meter, lancets, lancing device, and test strips		pervision school	For sy anytir Befor After Prior Additi	ymptoms of hypo/hy ne the student does e PE/Activity PE/Activity to dismissal		
CONTINUOUS GLUCOSE MONITORING (CGM) Brand/Model:		(mg/dL)	check be glucose of hypog glucose	ays confirm CGM results with finger stick ck before taking action on sensor blood cose level. If student has symptoms or signs ypoglycemia, check finger stick blood cose level regardless of CGM. Then student complains of nausea, vomiting,		
☐ URINE KETONE TESTING ☐ BLOOD KETONE TESTING	abdominal pain. See p management.	page 3 for further	er instructi	ons under hypergly	cemia	
NAME OF MEDICATION	DOSE/F	POLITE		TI	ME	
☐ GLUCAGON - INJECTABLE	0.5 mg subq/IM	KOOTE		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) to be administered at school	mg po	AM or F	PM	Nausea/vomiting, diarrhea	Clear liquids	
Other:® to be administered at school						
Additional Instructions:			Į.		•	
Specific duration of order: 2011 - 2012 SCHOOL YEAR	r Signature: Provider P	rinted Name:		Office Phone: XXX Office Fax: XXX Emergency #)		

Name of Institution

Institution Address

DEPARTMENT

DIABETES MEDICAL MANAGEMENT PLAN INTENSIVE THERAPY

Page 2 of 3

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

Office Fax: xxx-xxx-xxxx

Emergency # xxx-xxx-xxxx

SCHOOL YEAR 2010-2011 DIABETES SCHOOL CARE PLAN Student:

Intensive Therapy/Multiple Daily Injections Effective date: 1/13/2011

Definitions

Insulin-to-Carbohydra (CHO Ratio)	ate Ratio			Sensitivity ion Factor)	Target Blood Glucose
the amount of insulin nec prevent hyperglycemia a a specified amount of call	fter ingestion of	the predicted drop in blood glucose concentration after administration of 1 unit of regular or rapid-acting insulin			a specific blood glucose value used to determine the correction dose of insulin administered with a meal
usually expressed as "1 umular grams of carbohydra"				as "1 unit for every lucose is > target"	
			11101	11 151	
				JLIN	
Insulin to be given during s		Yes 📗	No Timin	□ May calculate/give	own injections with supervision
Rapid-acting Insulin (all doses to be admin	nistered subcutant units at acting insulin	_am or pm	➤ If C	Rapid-acting Insulin : meal if CHO intake HO intake cannot be pred	should always be given prior to Is snacks can be predetermined. determined insulin should be given no er completion of meal/snack.
·		**			administration of meal or snack insulin.
	sulin based on the	amount of carbo			(if needed) - the student requires meal time re additional insulin to correct blood glucose
Insulin Dose = [(Actual B	G – Target pre	-meal BG) divi	ded by I	nsulin Sensitivity] + [#	carbohydrates consumed/CHO Ratio]
					r, may yield an even amount of insulin ctivity follows meal, then may round down).
Target pre-meal BG: _	mg/dL			Insulin Sensitivity/C _ unit for ev	Correction Factor: very > target tatio:
CHO Ratio:	t r	Parent has permi to adjust CHO ra range from to 1:	tio in a	 Less insulin may be re 	equired with meals prior to physical activity in oglycemia. If so, the Exercise/PE CHO Ratio
☐ Correction insulin to	be administere	ed for elevate	d blood	glucose if 3 hours or	more after last insulin dose
•	e required prior to o	or after exercise ☐ Before Exer Insulin may be c	in order forcise ordered for	to prevent hypoglycemia. In After Exercise	nsulin is not administered with these snacks. Drevent post-meal hyperglycemia (see above)
Never provide insulin cove				to treat hypoglycemia.	
In general, there are no re A student should not exercuntil hypoglycemia/hyperg A source of fast-acting gluents.	cise if his/her blood lycemia is resolve	d glucose is < d.	mg/	dL or > 300 mg/dL (with pos	sitive ketones) immediately prior to exercise or
Specific duration of order: Phys	sician/Provider Sig	gnature: F	Provider I	Printed Name:	Office Phone: xxx-xxx-xxxx

2011 - 2012

SCHOOL YEAR

NAME OF INSTITUTION

Institution Address

DEPARTMENT DIABETES MEDICAL MANAGEMENT PLAN INTENSIVE THERAPY

Page 3 of 3

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

SCHOOL YEAR 2010-2011 DIABETES SCHOOL CARE PLAN Student:

Effective date: 1/13/2011

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 grams 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 (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 xxx-xxx-xxxx.

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 to small (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 xxx-xxxx 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: 1/13/2011
Acknowledged and received by:	Parent/Legal Guardian:		Date:
Acknowledged and received by:	School Representative:		Date:

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)	tudent Name (Last, First, MI)			Student's Date of Birth		
School		Student's G	Grade:	Home Phon	е	
Parent Name		Work/Cell F	Phone			
Home Address		City		State, Zip co	ode	
Student's Diagnosis: DIABETES: Other	☐ Type 1 ☐ Type 2	Today's Da	ite			
MONITORING						
BLOOD GLUCOSE (BG) MONITORING with meter, lancets, lancing device, and test strips	Yes No	vision nool personnel	For anyt Befor Afte Prio	re meals symptoms of hypo/hyp ime the student does re PE/Activity to dismissal tional BG monitoring nt's request		
CONTINUOUS GLUCOSE MONITORING (CGM) Brand/Model:	Yes No		check be glucose I of hypog	s confirm CGM results with finger stick before taking action on sensor blood se level. If student has symptoms or signs oglycemia, check finger stick blood se level regardless of CGM.		
☐ URINE KETONE TESTING BLOOD KETONE TESTING	Anytime the <u>BG ></u> abdominal pain. See part management.			t complains of naus ons under hypergly		
NAME OF MEDICATION	DOSE/R	ROUTE		TI	ME	
GLUCAGON - INJECTABLE	0.5 mg subq/IM 1.0 mg subq/IM			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:						
Additional Instructions:			т			
Specific duration of order: 2011 - 2012 SCHOOL YEAR	r Signature: Provider Pr	inted Name:		Office Phone: Office Fax: Emergency #		

DIABETES MEDICAL MANAGEMENT PLAN CONVENTIONAL THERAPY or TYPE 2 Page 2 of 3

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

SCHOOL YEAR 2010-2011 DIABETES SCHOOL CARE PLAN
CONVENTIONAL THERAPY OR TYPE 2 DIABETES

Effective date:

CONVENTIONAL II	HERAPI OR TIPE 2 D	IADETES) Ellectiv	ve date
		INS	ULIN	
Insulin to be given durin	g school hours: Yes	□ No	_	ister insulin if supervised ister his/her own insulin minister insulin
Insulin Types:		☐ Meal		
Rapid-acting Insulin		☐ ac	cording to the following d	istribution:
☐ Short-acting Insulin	Гуре: Regular	Br	eakfast: grams	
Intermediate-acting I		AN	M Snack: grams	
may mix with rapid	d or short-acting insulin	Lu	ınch: grams	
☐ Long-acting Insulin T		PN	M Snack: grams	
	units atam or pm		outio:CUO Datio: 1 unit fo	r over arome of CHO
may mix with rapi	d-acting insulin		decrease by 1 unit if pre-lung	r every grams of CHO ch reading is less than 80 mg/dL or if
(all doses to be adm	inistered subcutaneously)		strenuous exercise if anticipa	
☐ Pre-breakfast dose:	Regular units Humak	og® or Novol	og® or Apidra® units	NPHunits
			og® or Apidra® units	
Pre-dinner dose:	Regular units Humak	og® or Novol	og® or Apidra® units	NPH units
□ Sliding scale to be a	administered at (time		□ Insulin Sensitivity (Correction Factor) to be
	,	-,	administered at	(times)
If blood glucose	Units of rapid-acting Insulir	า subq	the predicted drop in	blood glucose concentration after
	give			nit of regular or rapid-acting insulin "" unit for everymg/dl blood glucose is
	give		> target"	I dilition everymigral blood gladese is
	give		If uneven, then round	to the nearest half or whole unit (May use
	give		clinical discretion; if p	physical activity follows meal, then may round
	give		uowii)	
	give		Sensitivity:	
			Target:	
			raiget.	
☐ Other Instructions:				
<u>Snacks</u>				
				here to CHO amounts ordered above). sulin is not administered with these snacks.
• Sulleduled shacks may	be required prior to or after exer		☐ After Exercise	Sulli 15 flot auffillistered with these shacks.
For de manufacturation at	-		_	(a a a toron a laborar a reduce residue a laborar a lab
	: unscheduled times. Insulin may carbohydrates consumed/CHO R		or these snacks in order to p	prevent post-meal hyperglycemia (see above).
	overage for carbohydrate/glucos		to treat hypoglycemia.	
Exercise and Sports	-	-		
_		:£:		
•	o restrictions on activity unless sp kercise if his/her blood glucose is		or > 300 mg/dL and ketones	s are positive
	glucose & glucagon (if ordered)	•	ŭ .	•
O a self and a self a self a self a	Dhysisian/Dravidar Cignatura	Drovidor F	Printed Name'	05. 51
Specific duration of order: 2011 - 2012	Physician/Provider Signature:	Piovidei F	Printed Name:	Office Phone: Office Fax:
SCHOOL YEAR				Emergency #
SCHOOL LEAK				Lillergericy #

DIABETES MEDICAL MANAGEMENT PLAN CONVENTIONAL THERAPY or TYPE 2

Page 3 of 3

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

SCHOOL YEAR 2010-201	1 DIABETES S	CHOOL CARE PLAN	N Student:			
Effective				late:		
Hypoglycemia (Low Blood (<u>Glucose)</u>					
Hypoglycemia is defined as a blo	od glucose <	_ mg/dL				
Signs of hypoglycemia:						
	Hunger	Sweating	Shakiness	Paleness	Dizziness	
	Confusion	Loss of coordination	Fatique	Fighting	Crying	
If hypoglycemia is	Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure	
suspected, check the blood glud	cose level.					
Hypoglycemia	his/her airwa Place stud If glucagor Mild or Mode gram fast-act 3-4 glucos		or seizing, admi	inister glucagon. nce, and call Parents/L	egal Guardian.	
Management		of regular soda/juice or				
(Low Blood Glucose)		oe Glucose/Cake gel				
		heck 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 				
		ceptable range and at lunch contact the contact is contacted and the contact	·		•	
		peanut butter or cheese crac			aseu CHO	
		e the BG > 70 mg/dL despite				

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 sugarfree 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 Address

DEPARTMENT

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.

<u>Notice to Parents</u>: 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:

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Student Name (Last, First, MI)		Student's Date of Birth			
School		Student's Grade: Home Phone			
Parent Name		Work/Cell F	Phone	1	
Home Address	City		State, Zip co	ode	
Student's Diagnosis: DIABETES: Other	Type 1 ☐Type 2	Today's Da 1/13/2011	ite	,	
	MONITO	ORING			
BLOOD GLUCOSE (BG) MONITORING with meter, lancets, lancing device, and test strips	Yes No ☐ Student requires super ☐ To be performed by scl ☐ Student is independent ☐ Permission to self-carry	vision hool personnel	For anyt	re meals symptoms of hypo/hy me the student does re PE/Activity PE/Activity to dismissal tional BG monitoring nt's request	
Duon d'Model		(mg/dL)	of hypoglycemia, check finger stick blood		
☐ URINE KETONE TESTING ☐ BLOOD KETONE TESTING	Anytime the <u>BG ></u> abdominal pain. See part management.	_ mg/dL or wh age 3 for furthe	en studen er instructi	t complains of naus ons under hypergly	sea, vomiting, cemia
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 control his/her airway or unable to swor seizing		onscious (unable to or unable to swallow),	
ORAL MEDICATIONS	DOSAGE	TIME		POSSIBLE SIDE EFFECTS	TREATMENT SIDE EFFECTS
Glucophage® (Metformin) mg po		AM or F		Nausea/vomiting, diarrhea	Clear liquids
Other: to be administered at school Additional Instructions:					
	r Signaturo: Provider Dr	inted Name:		Office Dis	
Specific duration of order: Physician/Provider 2011 - 2012 SCHOOL YEAR	inted Name:			XXX-XXXX XXX-XXXX XXX-XXX	

Institution Address

DEPARTMENT DIABETES MEDICAL MANAGEMENT PLAN CONVENTIONAL THERAPY or TYPE 2

Page 2 of 3

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

SCHOOL YEAR 2010-2011 DIABETES SCHOOL CARE PLAN CONVENTIONAL THERAPY OR TYPE 2 DIABETES Effective date: 1/13/2011

INSULIN Insulin to be given during school hours: ☐ Yes □No ☐ Student can administer insulin if supervised **Insulin Types:** Meal Plan: Rapid-acting Insulin Type: according to the following distribution: Short-acting Insulin Type: Regular Breakfast: _____ grams AM Snack: ____ grams ☐ Intermediate-acting Insulin Type: **NPH** may mix with rapid or short-acting insulin Lunch: grams PM Snack: grams ☐ Long-acting Insulin Type: units at am or pm ☐ 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 may mix with rapid-acting insulin strenuous exercise if anticipated. (all doses to be administered subcutaneously) ☐ Pre-breakfast dose: Regular ____ units Humalog® or Novolog® or Apidra® _____ units NPH ____ units Humalog® or Novolog® or Apidra® _____ units ☐ Pre-lunch dose: Regular ____ units NPH ____ units Humalog® or Novolog® or Apidra® _____ units ☐ Pre-dinner dose: Regular ____ units NPH ____ units □ Sliding scale to be administered at ____ (times) ☐ Insulin Sensitivity (Correction Factor) to be administered at _____ (times) Units of rapid-acting Insulin subq • the predicted drop in blood glucose concentration after If blood glucose administration of 1 unit of regular or rapid-acting insulin _____ give ____ usually expressed as "1 unit for every ____mg/dl blood glucose is _____ give _____ > target" _____ give _____ If uneven, then round to the nearest half or whole unit (May use clinical discretion; if physical activity follows meal, then may round _____ give _____ down) _____ give _____ _____ give _____ 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.

Exercise and Sports

• In general, there are no restrictions on activity unless specified.

Snack time insulin = # carbohydrates consumed/CHO Ratio.

A student should not exercise if his/her blood glucose is <100 mg/dL or > 300 mg/dL and ketones are positive.

☐ Before Exercise

• A source of fast-acting glucose & glucagon (if ordered) should be available in case of hypoglycemia.

Never provide insulin coverage for carbohydrate/glucose being used to treat hypoglycemia.

Specific duration of order:	Physician/Provider Signature:	Provider Printed Name:	Office Phone: xxx-xxx-xxxx
2011 - 2012			Office Fax: xxx-xxx-xxxx
SCHOOL YEAR			Emergency # xxx-xxx-xxxx

Foods may be eaten at unscheduled times. Insulin may be ordered for these snacks in order to prevent post-meal hyperglycemia (see above).

☐ After Exercise

Institution Address

DEPARTMENT DIABETES MEDICAL MANAGEMENT PLAN CONVENTIONAL THERAPY or TYPE 2

Page 3 of 3

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

SCHOOL YEAR 2010-2011 DIABETES SCHOOL CARE PLAN Student:

Effective date: 1/13/2011

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 XXX-XXXX.

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 sugarfree 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 XXX-XXXX 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: 1/13/2011
Acknowledged and received by:	Parent/Legal Guardian:		Date:
Acknowledged and received by:	School Representative:		Date:

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			е	
Parent Name		Work/Cell F	Phone			
Home Address		City		State, Zip co	ode	
Student's Diagnosis: DIABETES: Other	Today's Da	ite				
	MONITORING					
BLOOD GLUCOSE (BG) MONITORING with meter, lancets, lancing device, and test strips	Yes No	vision nool personnel	For anyt Befor Afte Prio	re meals symptoms of hypo/hyp ime the student does re PE/Activity to dismissal tional BG monitoring nt's request		
Drand/Madali		(mg/dL)	check be glucose I of hypog	ays confirm CGM results with finger stick on before taking action on sensor blood cose level. If student has symptoms or signs proglycemia, check finger stick blood cose level regardless of CGM.		
☐ URINE KETONE TESTING BLOOD KETONE TESTING	Anytime the <u>BG ></u> abdominal pain. See part management.			t complains of naus ons under hypergly		
NAME OF MEDICATION	DOSE/R	OUTE TIME			ME	
GLUCAGON - INJECTABLE	0.5 mg subq/IM 1.0 mg subq/IM			or seizing		
ORAL MEDICATIONS	DOSAGE	TIME		POSSIBLE SIDE EFFECTS	TREATMENT SIDE EFFECTS	
Glucophage® (Metformin) mg po		AM or F		Nausea/vomiting, diarrhea	Clear liquids	
Other:						
Additional Instructions:			т			
Specific duration of order: 2011 - 2012 SCHOOL YEAR	inted Name:		Office Phone: Office Fax: Emergency #			

DIABETES MEDICAL MANAGEMENT PLAN CONVENTIONAL THERAPY or TYPE 2 Page 2 of 3

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

SCHOOL YEAR 2010-2011 DIABETES SCHOOL CARE PLAN
CONVENTIONAL THERAPY OR TYPE 2 DIABETES

Effective date:

CONVENTIONAL II	HERAPI OR TIPE 2 D	IADETES) Ellectiv	ve date
		INS	ULIN	
Insulin to be given durin	g school hours: Yes	□ No	_	ister insulin if supervised ister his/her own insulin minister insulin
Insulin Types:		☐ Meal		
Rapid-acting Insulin		☐ ac	cording to the following d	istribution:
☐ Short-acting Insulin	Гуре: Regular	Br	eakfast: grams	
Intermediate-acting I		AN	M Snack: grams	
may mix with rapid	d or short-acting insulin	Lu	ınch: grams	
☐ Long-acting Insulin T		PN	M Snack: grams	
	units atam or pm		outio:CUO Datio: 1 unit fo	r over arome of CHO
may mix with rapi	d-acting insulin		decrease by 1 unit if pre-lung	r every grams of CHO ch reading is less than 80 mg/dL or if
(all doses to be adm	inistered subcutaneously)		strenuous exercise if anticipa	
☐ Pre-breakfast dose:	Regular units Humak	og® or Novol	og® or Apidra® units	NPHunits
			og® or Apidra® units	
Pre-dinner dose:	Regular units Humak	og® or Novol	og® or Apidra® units	NPH units
□ Sliding scale to be a	administered at (time		□ Insulin Sensitivity (Correction Factor) to be
	,	-,	administered at	(times)
If blood glucose	Units of rapid-acting Insulir	า subq	the predicted drop in	blood glucose concentration after
	give			nit of regular or rapid-acting insulin "" unit for everymg/dl blood glucose is
	give		> target"	I dilition everymigral blood gladese is
	give		If uneven, then round	to the nearest half or whole unit (May use
	give		clinical discretion; if p	physical activity follows meal, then may round
	give		uowii)	
	give		Sensitivity:	
			Target:	
			raiget.	
☐ Other Instructions:				
<u>Snacks</u>				
				here to CHO amounts ordered above). sulin is not administered with these snacks.
• Sulleduled shacks may	be required prior to or after exer		☐ After Exercise	Sulli 15 flot auffillistered with these shacks.
For de manufacturation at	-		_	(a a a toron a laborar a reduce residue a laborar a lab
	: unscheduled times. Insulin may carbohydrates consumed/CHO R		or these snacks in order to p	prevent post-meal hyperglycemia (see above).
	overage for carbohydrate/glucos		to treat hypoglycemia.	
Exercise and Sports	-	-		
_		:£:		
•	o restrictions on activity unless sp kercise if his/her blood glucose is		or > 300 mg/dL and ketones	s are positive
	glucose & glucagon (if ordered)	•	ŭ .	•
O a self and a self a self a self a	Dhysisian/Dravidar Cignatura	Drovidor F	Printed Name'	05. 51
Specific duration of order: 2011 - 2012	Physician/Provider Signature:	Piovidei F	Printed Name:	Office Phone: Office Fax:
SCHOOL YEAR				Emergency #
SCHOOL LEAK				Lillergericy #

DIABETES MEDICAL MANAGEMENT PLAN CONVENTIONAL THERAPY or TYPE 2

Page 3 of 3

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

SCHOOL YEAR 2010-201	1 DIABETES S	CHOOL CARE PLAN	N Student:				
Effective				late:			
Hypoglycemia (Low Blood (<u>Glucose)</u>						
Hypoglycemia is defined as a blo	od glucose <	_ mg/dL					
Signs of hypoglycemia:							
	Hunger	Sweating	Shakiness	Paleness	Dizziness		
	Confusion	Loss of coordination	Fatique	Fighting	Crying		
If hypoglycemia is	Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure		
suspected, check the blood glud	cose level.						
Hypoglycemia	his/her airwa Place stud If glucagor Mild or Mode gram fast-act 3-4 glucos		or seizing, admi	inister glucagon. nce, and call Parents/L	egal Guardian.		
Management		of regular soda/juice or					
(Low Blood Glucose)		oe Glucose/Cake gel					
		heck 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 16 BG in acceptable range and at lunch or snack time, respectitory and acceptable range and acceptable range and acceptable range. 16 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) 					
		e the BG > 70 mg/dL despite					

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 sugarfree 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 Address

DEPARTMENT DIABETES MEDICAL MANAGEMENT PLAN

Page 1 of 2

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

Effective date: 1/13/2011

Part 3: Insulin Pump Supplement

To be completed by physician/provider, diabetes educator and parent/guardian.

Student Name:			Date of Birth:			
Pump Brand/Model:	тм	Pump Cor	npany Technical Assistanc	e Num	ber:	
Pump Trainer/Resource Person:	Phor	ne/Beeper:				
Child-Lock On? ☐ Yes ☐ No How long has student worn an inst			to Cozmo Deltec™ Pump	only)		
Patient is new to pump the	erany and is t		or		(date)	
			UMP SETTINGS		(date)	
			of Insulin Dose (Bolus Ins	ulin):		
Rapid-acting Insulin Type: _			Rapid-acting Insulin sh	iould al		
		+	☐ meals			
Use pump bolus calculator to d		□ If CH	if CHO intake c		d insulin should be given no more	
meal, snack and correction doses pump malfunction occurs.	unless set or		30 minutes after completic			
' '		> Trea	it hypoglycemia before adn	ninistra	tion of meal or snack insulin.	
Calculating Insulin Doses: According insulin based on the amount of carboth the following formula:					s meal time coverage with rapid-acting loose to the desired range according to	
Insulin Dose = [(Actual BG – Tar	get pre-meal B	G) divided b	y Insulin Sensitivity] + [#	carbo	hydrates consumed/CHO Ratio]	
Fractional amounts of insulin from						
If uneven, then round to the neare	est whole or half u	<u>unit</u> (May use	clinical discretion; if physical	activity	follows meal, then may round down).	
Target pre-meal BG: r	ng/dL		Insulin Sensitivity/Co _ unit for eve			
CHO Ratio:	Parent has p	permission			☐ Not Applicable	
CHO Ratio.	to adjust CH				h meals prior to physical activity in	
	range from	4.	order to prevent hypogl	ycemia.	If so, the Exercise/PE CHO Ratio	
	1: to		should be used instead			
Extra pump supplies to be furnished dressings/tape insuling			ifusion sets reservoirs ☐ pump manufacturer in			
STU	JDENT PUMP S	KILLS		Comr	nents/Additional Instructions:	
Count carbohydrates		☐ Indepen	dent			
2. Bolus for carbohydrates consume	d	☐ Indepen	ndent			
Calculate and administer correction	on bolus	☐ Indepen	dent			
4. Disconnect pump		☐ Indepen	dent			
5. Reconnect pump at infusion set	5. Reconnect pump at infusion set ☐ Independent		dent	School	ol nurses/personnel are not	
6. Access bolus history on pump		☐ Indepen	☐ Independent ☐ Needs Assistance routi		nely trained on use of specific	
, , ,		☐ Independent		insulin pumps. School personnel will not perform pump operation without training		
8. Insert infusion set		☐ Independent			(to be coordinated with school by caregiver and healthcare provider). If	
9. Use & programming of		☐ Independent ☐ Needs Assistance		child	is not independent and trained	
square/extended/dual/combo bolus features —					RN/personnel are not available, parent/guardian to be contacted for set	
exercise and illness		☐ Independent ☐ Needs Assistance		change. Insulin by injection until set is changed per DMMP orders. If administering via injection, pump must be suspended or disconnected unless ordered otherwise.		
11. Give injection with syringe or pen, if needed		☐ Independent ☐ Needs Assistance				
12. Re-program pump settings if needed		☐ Independent ☐ Needs Assistance				
13. Trouble shoot alarms and malfunctions						
	ovider Signature: :	Provi	der Printed Name:		Office Phone: xxx-xxx-xxxx	
order: 2011 - 2012					Office Fax: xxx-xxx-xxxx	
SCHOOL YEAR					Emergency # xxx-xxx-xxxx	

NAME OF INSTITUTION

Institution Address

DEPARTMENT DIABETES MEDICAL MANAGEMENT PLAN

Page 2 of 2

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

Date:

Part 3: Insulin Pump Supplement (continued)

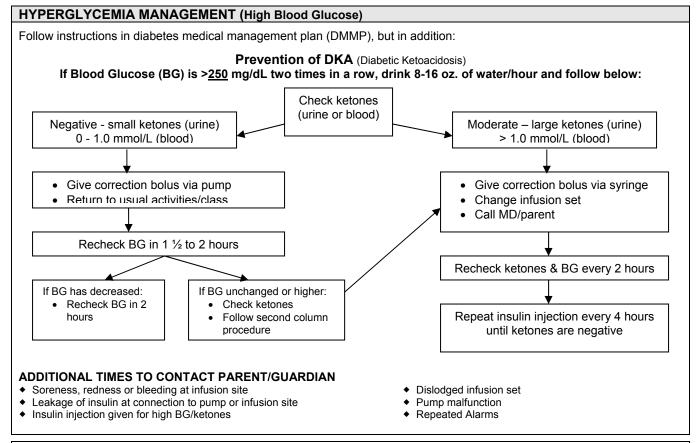
Student Name:

HYPOGLYCEMIA MANAGEMENT (Low Blood Glucose):

Follow instructions in DMMP, but in addition:

If seizure or unresponsiveness occurs:

- 1. <u>Treat with Glucagon</u> (See Diabetes Medical Management Plan)
- 2. **Call 911** (or designate another individual to do so)
- 3. Stop insulin pump by any of the following methods (Send pump with EMS to hospital):
 - Placing in "suspend" or stop mode (See manufacturer's instructions)
 - Disconnecting at site, pigtail or clip
 - Cutting tubing
- 4. Notify parent
- 5. If pump was removed, send with EMS to hospital



Other Instructions:

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.

School plan reviewed by:

Physician/Provider
Signature:

Parent/Legal Guardian:

Parent/Legal Guardian:

Date:

School Representative:

Acknowledged and received by:

DIABETES MEDICAL MANAGEMENT PLAN

SCHOOL YEAR

Page 1 of 2

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

Part 3: Insulin Pump Supplement To be completed by physician/provider, diabetes educator and p			Effective date:			
Student Name: Pump Brand/Model:	TM	Pumn Con	Date of Birth: npany Technical Assistanc	e Numb	er.	
		ne/Beeper:	npany recrimed Assistance	CINUIND	<u> </u>	
Child-Lock On?			to Cozmo Deltec™ Pump	only)		
	t worn an insulin pump?		or			
☐ Patient is new t	to pump therapy and is to				(date)	
	INS	_	UMP SETTINGS			
☐ Rapid-acting Ins	sulin Type:®	Timing	of Insulin Dose (Bolus Ins Rapid-acting Insulin sh		vays be given prior to	
		-	☐ meals		snacks	
	alculator to determine all	▶ If CH	if CHO intake c		reaeterminea. I insulin should be given no more	
pump malfunction occ	ection doses unless set or		30 minutes after completic			
1		> Trea	t hypoglycemia before adn	ninistrati	on of meal or snack insulin.	
insulin based on the am the following formula:	ses: According to CHO ratio and ount of carbohydrates in meal an	d Correction F d may require	actor (if needed) - the student e additional insulin to correct b	requires	meal time coverage with rapid-acting cose to the desired range according to	
	ual BG – Target pre-meal B	G) divided b	v Insulin Sensitivitv1 + [#	carboh	ydrates consumed/CHO Ratio]	
	s of insulin from correction and ca	-	-		-	
					ollows meal, then may round down).	
Target pre-meal B	G: ma/dL		Insulin Sensitivity/Co			
311	<u> </u>		_ unit for eve	ery	> target	
CHO Ratio:	Parent has permission to adjust CHO ratio in a range from 1: to 1:			meals prior to physical activity in If so, the Exercise/PE CHO Ratio		
Extra pump supplies	to be furnished by parent/gua		fusion sets ⊠ reservoirs ⊠ pump manufacturer ii			
Z dressings/tape	STUDENT PUMP S		△ pamp manalacturer ii		ents/Additional Instructions:	
Count carbohydrate		1	dent			
Bolus for carbohyd			dent Needs Assistance			
,	inister correction bolus		dependent Needs Assistance			
	mister correction bolds	= .	<u>_</u>			
	A tin E colonia and		dent Needs Assistance			
· ' '			☐ Independent ☐ Needs Assistance		School nurses/personnel are not routinely trained on use of specific	
6. Access bolus history on pump		☐ Independent ☐ Needs Assistance		insulin pumps. School personnel will not perform pump operation without training (to be coordinated with school by		
7. Prepare reservoir and tubing		☐ Independent				
8. Insert infusion set	a of	☐ Indepen		caregi	ver and healthcare provider). If	
Use & programming of square/extended/dual/combo bolus features		☐ Independent ☐ Needs Assistance		child is not independent and trained RN/personnel are not available, parent/guardian to be contacted for set change. Insulin by injection until set is		
Use and programming of temporary basals for exercise and illness		☐ Independent ☐ Needs Assistance				
11. Give injection with syringe or pen, if needed		☐ Indepen	dent Needs Assistance	changed per DMMP orders. If administering via injection, pump must be		
12. Re-program pump settings if needed		☐ Independent ☐ Needs Assistance		suspe	nded or disconnected unless	
13. Trouble shoot alarms and malfunctions		☐ Indepen	dent	ordere	d otherwise.	
Institution Form #						
Specific duration of	Physician/Provider Signature: :	Provid	der Printed Name:		Office Phone:	
order: 2011 - 2012					Office Fax:	
SCHOOL VEAR					Emergency #	

DIABETES MEDICAL MANAGEMENT PLAN

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service Page 2 of 2

Part 3: Insulin Pump Supplement (continued)

Student Name: Effective Date:

HYPOGLYCEMIA MANAGEMENT (Low Blood Glucose):

Follow instructions in DMMP, but in addition:

If seizure or unresponsiveness occurs:

- 1. Treat with Glucagon (See Diabetes Medical Management Plan)
- Call 911 (or designate another individual to do so)
- **Stop insulin pump** by any of the following methods (Send pump with EMS to hospital):
 - Placing in "suspend" or stop mode (See manufacturer's instructions)
 - Disconnecting at site, pigtail or clip
 - Cutting tubing
- Notify parent
- If pump was removed, send with EMS to hospital

HYPERGLYCEMIA MANAGEMENT (High Blood Glucose) Follow instructions in diabetes medical management plan (DMMP), but in addition: Prevention of DKA (Diabetic Ketoacidosis) If Blood Glucose (BG) is >250 mg/dL two times in a row, drink 8-16 oz. of water/hour and follow below: Check ketones (urine or blood) Negative - small ketones (urine) Moderate – large ketones (urine) 0 - 1.0 mmol/L (blood) > 1.0 mmol/L (blood) Give correction bolus via pump Give correction bolus via syringe Return to usual activities/class Change infusion set Call MD/parent Recheck BG in 1 1/2 to 2 hours Recheck ketones & BG every 2 hours If BG has decreased: If BG unchanged or higher: Recheck BG in 2 Check ketones Repeat insulin injection every 4 hours hours Follow second column procedure until ketones are negative ADDITIONAL TIMES TO CONTACT PARENT/GUARDIAN • Soreness, redness or bleeding at infusion site Dislodged infusion set Pump malfunction ◆ Leakage of insulin at connection to pump or infusion site ◆ Insulin injection given for high BG/ketones Repeated Alarms

Other Instructions:

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

Institution Address

DEPARTMENT DIABETES MEDICAL MANAGEMENT PLAN

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

Part 4: Permission to Self-Carry and Self Administer Diabetes Care

To be completed by physician/provider, parent/guardian and student. This form is not required by law, but serves to inform everyone of expectations and responsibilities.

Student Name: ______ Birthdate: ______

Student's physician or licensed nurse practitioner confirms that the student has a diagnosis of diabetes, is independent and can perform diabetes care, and has approval to self-administer his/her diabetes care including: _____ glucose monitoring

insulin calculation and administration (including pump operation & pump equipment)

The student understands that he/she is to promptly report to the school nurse or adult as soon as symptoms of high or low blood glucose appear or when not feeling well.

I agree to prepare a written Diabetes Medical Management Plan in consultation with student's parents and appropriate school personnel.

Specific duration of order:	Physician/Provider Signature:	Provider Printed Name:	Office Phone: xxx-xxx-xxxx
2011 - 2012			Office Fax: xxx-xxx-xxxx
SCHOOL YEAR			Date: <u>1/13/2011</u>

My child has been instructed in and understands his/her diabetic self-management. My child understands that he/ she is responsible and accountable for carrying and using his/her medication and equipment.

I will provide the school nurse/school administrator with a copy of my child's Diabetes Medical Management Plan signed by his/her physician.

I hereby give permission for the school to administer the medications as prescribed in the care plan, if indicated (ie. Student requests assistance or becomes unable to perform self-care).

I also give permission for the school to contact the above physician/nurse practitioner regarding my child's diabetes care (authorization required if contact is other than the school nurse).

I will not hold the school board or any of its employees liable for any negative outcomes resulting from the self-administration of diabetes medication by my child.

I understand that the school nurse, after consultation with the parent/guardian and school administrator, may impose reasonable limitations or restrictions upon my child's possession and self-administration of diabetes medications relative to his/her age and maturity or other relevant considerations.

I understand that the school administration may revoke permission to posses and self-administer said diabetes medication at any point during the school year if it is determined that my child has abused the privilege of possession and self-administration or he/she is not safely and effectively self-administering the medication. In addition, my child could be subject to further disciplinary action.

Parent/Guardian Signature	Date	
•		
Student Signature	Date	

Institution Address

DEPARTMENT DIABETES MEDICAL MANAGEMENT PLAN

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

	ion to Self-Carry and Se sician/provider, parent/guardian a s and responsibilities.		
Student Name:		Birthda	te:
			nt has a diagnosis of diabetes, is his/her diabetes care including:
☐ glucose m	onitoring		
insulin cal	culation and administration (inc	cluding pump operation & pun	np equipment)
	nds that he/she is to promptly roear or when not feeling well.	report to the school nurse or a	adult as soon as symptoms of high o
I agree to prepare appropriate school pe		Management Plan in const	ultation with student's parents and
Specific duration of order: 2011 - 2012 SCHOOL YEAR	Physician/Provider Signature: P	rovider Printed Name:	Office Phone: xxx-xxx-xxxx Office Fax: xxx-xxx-xxxx Date:
signed by his/her phys I hereby give permiss	sician.	er the medications as prescri	Diabetes Medical Management Plane bed in the care plan, if indicated (ie
	n for the school to contact the quired if contact is other than the		itioner regarding my child's diabetes
	hool board or any of its empetes medication by my child.	loyees liable for any negativ	ve outcomes resulting from the self
reasonable limitations		ld's possession and self-adr	nd school administrator, may impose ministration of diabetes medications
medication at any poi and self-administratio	nt during the school year if it is	s determined that my child ha	s and self-administer said diabetes as abused the privilege of possession the medication. In addition, my child
Parent/Guardian Sign	ature	 Date	

Date

Institution Form #

Student Signature