Virginia School Diabetes Medical Management Forms

Student _____ **School** _____ **Effective Date** _____

Date of Birth _____ **Grade** _____ **Homeroom Teacher** _____

Instructions:

1. **Part 1**- **Contact Information and Diabetes Medical History** . To be completed by parent/guardian and returned to school nurse (prior to beginning of each school year or upon diagnosis).
   ►Includes: Parent authorization for trained school designees to administer insulin and/or glucagon (required by Virginia Law).
2. **Part 2***- **Diabetes Medical Management Plan (DMMP)**. Student's physician/provider to complete Intensive Therapy or Conventional Therapy/Type 2 version of DMMP.
   Please note that physician authorization for treatment by trained school designees must be included in the Diabetes Medical Management Plan or a separate form must be provided.
3. **Part 3***- **Insulin Pump Supplement** . Have the physician/provider, diabetes educator, and parent/guardian collaborate to complete appropriate portions if your child wears an insulin pump.
4. **Part 4**- **Permission to Self-Carry and Self-Administer Diabetes Care** . To be completed by the physician/provider, school nurse and the parent/guardian if your child is going to carry and self administer insulin and/or perform blood glucose checks in the classroom.
5. **Virginia Diabetes Council School Diabetes Care Practice and Protocol** provides guidelines, accepted accommodations and references applicable to all students with diabetes. This document is available from your school nurse, the Department of Education Office of Student Services, or the Virginia Diabetes Council.

***Other Diabetes Medical Management Plans may be used for **Parts 2, 3 & 4** as long as all components are represented.

Return completed forms to the school nurse as quickly as possible. Thank you for your cooperation.

School nurse_____ Phone_____ Date_____

Part 1: Contact Information and Diabetes Medical History

To be completed by Parent/Guardian:

Parent/Guardian #1:_____

Address: _____

Telephone-Home: _____Work: _____ Cell: _____

Parent/Guardian #2:_____

Address: _____

Telephone-Home: _____Work: _____ Cell: _____

Other emergency contact: _____

Address: _____ Relationship: _____

Telephone-Home: _____Work: _____ Cell: _____

Physician managing diabetes: _____

Address: _____

Main Office #_____ Fax #_____ Emergency Phone #_____

Nurse/Diabetes Educator: _____ Office # _____

Student:

Medical History	Parent/Guardian Response (check appropriate boxes and complete blanks)
Diagnosis information	At what age? Type of diabetes?
How often is child seen by diabetes physician?	Frequency: Date of last visit:
Nutritional needs	♦ Snacks ❑ ____AM ❑ ____PM ❑ _____Prior to Exercise/Activity ❑ Only in case of low blood glucose ❑ Student may determine if CHO counting ❑ In the event of a class party may eat the treat (include insulin coverage if indicated in medical orders) ❑ student able to determine whether to eat the treat ❑ replace with parent supplied treat ❑ may NOT eat the treat ◆ Other _____
Child's most common signs of low blood glucose	❑ trembling ❑ tingling ❑ loss of coordination ❑ dizziness ❑ moist skin/sweating ❑ slurred speech ❑ heart pounding ❑ hunger ❑ confusion ❑ weakness ❑ fatigue ❑ seizure ❑ pale skin ❑ headache ❑ unconsciousness ❑ change in mood or behavior ❑ other _____
How often does child experience low blood glucose and how severe?	**Mild/Moderate** ❑ once a day ❑ once a week ❑ once a month Indicate date(s) of last mild/moderate episode(s) _____ What time of day is most common for hypoglycemia to occur? _____ **Severe** (i.e. unconscious, unable to swallow, seizure, or needed Glucagon) Include date(s) of recent episode(s) _____
Episode(s) of ketoacidosis	Include date(s) of recent episode(s)
Field trips	Parent/guardian will accompany child during field trips? ❑ 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	

I give permission to the school nurse and designated school personnel*, who have been trained and are under the supervision of the school nurse to perform and carry out the diabetes care tasks as outlined in my child's *Diabetes Medical Management Plan* as ordered by the physician. I give permission to the designated school personnel, who have been trained to perform the following diabetes care tasks for my child. (Code of Virginia§ 22.1-274).

Insulin Administration ☐ YES ☐ NO Glucagon Administration ☐ YES ☐ NO

I understand that I am to provide all supplies to the school necessary for the treatment of my child's diabetes. I also consent to the release of information contained in the Diabetes Medical Management Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also give permission to contact the above named physician and members of the diabetes management team regarding my child's diabetes should the need arise.

Parent/Guardian Name _____ **Date** _____

Parent/Guardian Signature_____

School Nurse's Name _____ **Date** _____

School Nurse's Signature _____

*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 Teacher** _____

Instructions:

1. **Part 1**- **Contact Information and Diabetes Medical History** . To be completed by parent/guardian and returned to school nurse (prior to beginning of each school year or upon diagnosis).
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Return completed forms to the school nurse as quickly as possible. Thank you for your cooperation.

School nurse_____ Phone_____ Date_____

Part 1: Contact Information and Diabetes Medical History

To be completed by Parent/Guardian:

Parent/Guardian #1:_____

Address: _____

Telephone-Home: _____Work: _____ Cell: _____

Parent/Guardian #2:_____

Address: _____

Telephone-Home: _____Work: _____ Cell: _____

Other emergency contact: _____

Address: _____ Relationship: _____

Telephone-Home: _____Work: _____ Cell: _____

Physician managing diabetes: _____

Address: _____

Main Office #_____ Fax #_____ Emergency Phone #_____

Nurse/Diabetes Educator: _____ Office # _____

Student:

Medical History	Parent/Guardian Response (check appropriate boxes and complete blanks)
Diagnosis information	At what age? Type of diabetes?
How often is child seen by diabetes physician?	Frequency: Date of last visit:
Nutritional needs	♦ Snacks ❑ ____AM ❑ ____PM ❑ _____Prior to Exercise/Activity ❑ Only in case of low blood glucose ❑ Student may determine if CHO counting ❑ In the event of a class party may eat the treat (include insulin coverage if indicated in medical orders) ❑ student able to determine whether to eat the treat ❑ replace with parent supplied treat ❑ may NOT eat the treat ◆ Other _____
Child's most common signs of low blood glucose	❑ trembling ❑ tingling ❑ loss of coordination ❑ dizziness ❑ moist skin/sweating ❑ slurred speech ❑ heart pounding ❑ hunger ❑ confusion ❑ weakness ❑ fatigue ❑ seizure ❑ pale skin ❑ headache ❑ unconsciousness ❑ change in mood or behavior ❑ other _____
How often does child experience low blood glucose and how severe?	**Mild/Moderate** ❑ once a day ❑ once a week ❑ once a month Indicate date(s) of last mild/moderate episode(s) _____ What time of day is most common for hypoglycemia to occur? _____ **Severe** (i.e. unconscious, unable to swallow, seizure, or needed Glucagon) Include date(s) of recent episode(s) _____
Episode(s) of ketoacidosis	Include date(s) of recent episode(s)
Field trips	Parent/guardian will accompany child during field trips? ❑ 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	

I give permission to the school nurse and designated school personnel*, who have been trained and are under the supervision of the school nurse to perform and carry out the diabetes care tasks as outlined in my child's *Diabetes Medical Management Plan* as ordered by the physician. I give permission to the designated school personnel, who have been trained to perform the following diabetes care tasks for my child. (Code of Virginia§ 22.1-274).

Insulin Administration ☐ YES ☐ NO Glucagon Administration ☐ YES ☐ NO

I understand that I am to provide all supplies to the school necessary for the treatment of my child's diabetes. I also consent to the release of information contained in the Diabetes Medical Management Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also give permission to contact the above named physician and members of the diabetes management team regarding my child's diabetes should the need arise.

Parent/Guardian Name _____ **Date** _____

Parent/Guardian Signature_____

School Nurse's Name _____ **Date** _____

School Nurse's Signature _____

*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.

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

Part 2: Virginia Diabetes Medical Management Plan (DMMP)

To be completed by physician/provider.

Notice to Parents: Medication(s) **MUST** be brought to school by the PARENT/GUARDIAN in a container that is appropriately labeled by the pharmacy or physician/practitioner.

In order for schools to safely administer medication during school hours, the following regulations should be observed:

- A new copy of the DMMP must be completed at the beginning of each school year. This form, an Authorization for Medication Administration form, or MD prescription must be received in order to change diabetes care at school during the school year.

Student Name (Last, First, MI)	Student's Date of Birth	
School	Student's Grade	Home Phone
Parent Name	Work/Cell Phone	
Home Address	City	State, Zip code
Student's Diagnosis: **DIABETES:** ☐ **Type 1** ☐ **Type 2** ☐ **Other**	Today's Date	

MONITORING		
BLOOD GLUCOSE (BG) MONITORING with meter, lancets, lancing device, and test strips	☐ Yes ☐ No ☐ 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	
	DOSAGE	**TIME**	**POSSIBLE SIDE EFFECTS**	**TREATMENT OF 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: **2011 - 2012** **SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: XXX-XXX-XXXX Office Fax: XXX-XXX-XXXX **Emergency # XXX-XXX-XXXX**

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

SCHOOL YEAR 2010-2011 DIABETES SCHOOL CARE PLAN Student:
Intensive Therapy/Multiple Daily Injections Effective date: 1/13/2011

Definitions

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

INSULIN

Insulin to be given during school hours: ☐ Yes ☐ No ☐ May calculate/give own injections with supervision

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

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

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

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

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

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

Target pre-meal BG: _____ mg/dL

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

CHO Ratio:

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

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

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

Snacks

- In general, children with diabetes managed using Intensive Therapy/MDI do not require snacks.
- Scheduled snacks may be required prior to or after exercise in order to prevent hypoglycemia. Insulin is not administered with these snacks.

☐ Before Exercise ☐ After Exercise

- Foods may be eaten at unscheduled times. Insulin may be ordered for these snacks in order to prevent post-meal hyperglycemia (see above).
- Snack time insulin = # carbohydrates consumed/CHO Ratio.
- Never provide insulin coverage for carbohydrate/glucose being used to treat hypoglycemia.

Exercise and Sports

- In general, there are no restrictions on activity unless specifically noted.
- A student should not exercise if his/her blood glucose is < _____ mg/dL or > 300 mg/dL (with positive ketones) immediately prior to exercise or until hypoglycemia/hyperglycemia is resolved.
- A source of fast-acting glucose & glucagon should be available in case of hypoglycemia.

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

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-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:

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: **2011 - 2012** **SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: _____ Office Fax: _____ **Emergency # _____**

Institution Form #

Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN
CONVENTIONAL THERAPY or TYPE 2

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

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:	Physician/Provider Signature: Provider Printed Name:	Office Phone: _____ Office Fax: _____
2011 - 2012 SCHOOL YEAR		**Emergency # _____**

Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN
CONVENTIONAL THERAPY or TYPE 2

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

SCHOOL YEAR 2010-2011 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 NAME
Institution Address
DEPARTMENT
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.

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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 **1/13/2011**	

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: **2011 - 2012** **SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: xxx-xxx-xxxx Office Fax: xxx-xxx-xxxx **Emergency # xxx-xxx-xxxx**

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

Student:
Effective date: 1/13/2011

INSULIN

Insulin to be given during school hours: ☐ Yes ☐ No | ☐ Student can administer insulin if supervised

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:	Physician/Provider Signature: Provider Printed Name:	Office Phone: xxx-xxx-xxxx Office Fax: xxx-xxx-xxxx
2011 - 2012 SCHOOL YEAR		**Emergency # xxx-xxx-xxxx**

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-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 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-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:

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: **2011 - 2012** **SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: _____ Office Fax: _____ **Emergency # _____**

Institution Form #

Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN
CONVENTIONAL THERAPY or TYPE 2

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

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:	Physician/Provider Signature: Provider Printed Name:	Office Phone: _____ Office Fax: _____
2011 - 2012 SCHOOL YEAR		**Emergency # _____**

Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN
CONVENTIONAL THERAPY or TYPE 2

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

SCHOOL YEAR 2010-2011 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 NAME
Institution Address

DEPARTMENT
DIABETES MEDICAL MANAGEMENT PLAN

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

Part 3: Insulin Pump Supplement

Effective date: 1/13/2011

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

Student Name: _____ Date of Birth: ____

Pump Brand/Model: _____™ Pump Company Technical Assistance Number: _____

Pump Trainer/Resource Person: Phone/Beeper:

Child-Lock On? ☐ Yes ☐ No Code: _17_ (applicable to Cozmo Deltec™ Pump only)

How long has student worn an insulin pump? _____ or

☐ **Patient is new to pump therapy and is to initiate use of pump on _____(date)**

INSULIN / PUMP SETTINGS

☐ Rapid-acting Insulin Type: _____®

☐ Use pump bolus calculator to determine all meal, snack and correction doses unless set or pump malfunction occurs.

Timing of Insulin Dose (Bolus Insulin):
Rapid-acting Insulin should always be given prior to
☐ meals ☐ snacks
if CHO intake can be predetermined.

- If CHO intake cannot be predetermined insulin should be given no more than 30 minutes after completion of meal/snack.
- Treat hypoglycemia before administration of meal or snack insulin.

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

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

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

Target pre-meal BG: _____ mg/dL

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

CHO Ratio:

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

Exercise/PE CHO Ratio: _____ ☐ Not Applicable

- Less insulin may be required with meals prior to physical activity in order to prevent hypoglycemia. If so, the Exercise/PE CHO Ratio should be used instead of the CHO Ratio.

Extra pump supplies to be furnished by parent/guardian: ☐ infusion sets ☐ reservoirs ☐ pods for OmniPod™ ☐ dressings/tape ☐ insulin ☐ syringes/insulin pen ☐ pump manufacturer instructions

STUDENT PUMP SKILLS		Comments/Additional Instructions:
1. Count carbohydrates	☐ Independent ☐ Needs Assistance	
2. Bolus for carbohydrates consumed	☐ Independent ☐ Needs Assistance	
3. Calculate and administer correction bolus	☐ Independent ☐ Needs Assistance	
4. Disconnect pump	☐ Independent ☐ Needs Assistance	
5. Reconnect pump at infusion set	☐ Independent ☐ Needs Assistance	**School nurses/personnel are not routinely trained on use of specific insulin pumps. School personnel will not perform pump operation without training (to be coordinated with school by caregiver and healthcare provider). If 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 changed per DMMP orders. If administering via injection, pump must be suspended or disconnected unless ordered otherwise.**
6. Access bolus history on pump	☐ Independent ☐ Needs Assistance	
7. Prepare reservoir and tubing	☐ Independent	
8. Insert infusion set	☐ Independent	
9. Use & programming of square/extended/dual/combo bolus features	☐ Independent ☐ Needs Assistance	
10. Use and programming of temporary basals for exercise and illness	☐ Independent ☐ Needs Assistance	
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	☐ Independent ☐ Needs Assistance	

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

Institution Form #

Part 3: Insulin Pump Supplement (continued)

Student Name: _____

HYPOGLYCEMIA MANAGEMENT (Low Blood Glucose):

Follow instructions in DMMP, but in addition:

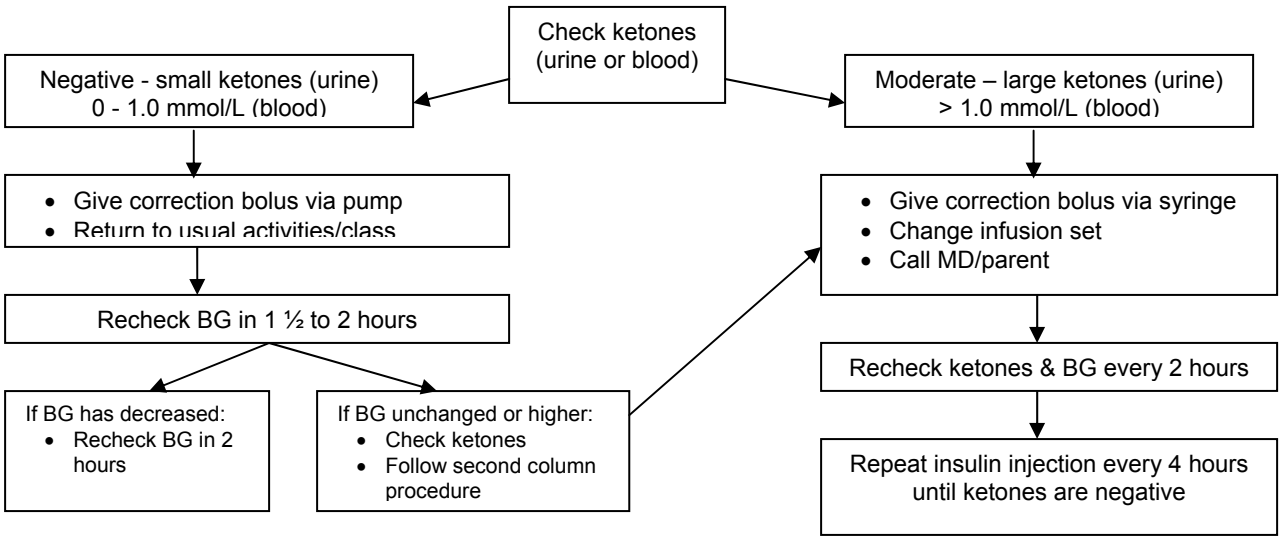
If seizure or unresponsiveness occurs:

1. **Treat with Glucagon** (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

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:



ADDITIONAL TIMES TO CONTACT PARENT/GUARDIAN

- Soreness, redness or bleeding at infusion site
- Leakage of insulin at connection to pump or infusion site
- Insulin injection given for high BG/ketones
- Dislodged infusion set
- Pump malfunction
- 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: 1/13/2011
Acknowledged and received by:	Parent/Legal Guardian:	Date:
Acknowledged and received by:	School Representative:	Date:

Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN

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

Part 3: Insulin Pump Supplement

Effective date: _____

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

Student Name: Date of Birth:

Pump Brand/Model: _____™ Pump Company Technical Assistance Number: _____

Pump Trainer/Resource Person: Phone/Beeper:

Child-Lock On? ☐ Yes ☐ No Code: 17 (applicable to Cozmo Deltec™ Pump only)

How long has student worn an insulin pump? _____ or

☐ **Patient is new to pump therapy and is to initiate use of pump on _____(date)**

INSULIN / PUMP SETTINGS

☐ Rapid-acting Insulin Type: _____®

☐ Use pump bolus calculator to determine all meal, snack and correction doses unless set or pump malfunction occurs.

Timing of Insulin Dose (Bolus Insulin):

Rapid-acting Insulin should always be given prior to
☐ meals ☐ snacks
if CHO intake can be predetermined.

- If CHO intake cannot be predetermined insulin should be given no more than 30 minutes after completion of meal/snack.
- Treat hypoglycemia before administration of meal or snack insulin.

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

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

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

Target pre-meal BG: _____ mg/dL

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

CHO Ratio:

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

Exercise/PE CHO Ratio: _____ ☐ Not Applicable

- Less insulin may be required with meals prior to physical activity in order to prevent hypoglycemia. If so, the Exercise/PE CHO Ratio should be used instead of the CHO Ratio.

Extra pump supplies to be furnished by parent/guardian: ☒ infusion sets ☒ reservoirs ☐ pods for OmniPod™
☒ dressings/tape ☒ insulin ☒ syringes/insulin pen ☒ pump manufacturer instructions

STUDENT PUMP SKILLS		Comments/Additional Instructions:
1. Count carbohydrates	☐ Independent ☐ Needs Assistance	
2. Bolus for carbohydrates consumed	☐ Independent ☐ Needs Assistance	
3. Calculate and administer correction bolus	☐ Independent ☐ Needs Assistance	
4. Disconnect pump	☐ Independent ☐ Needs Assistance	
5. Reconnect pump at infusion set	☐ Independent ☐ Needs Assistance	**School nurses/personnel are not routinely trained on use of specific insulin pumps. School personnel will not perform pump operation without training (to be coordinated with school by caregiver and healthcare provider). If 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 changed per DMMP orders. If administering via injection, pump must be suspended or disconnected unless ordered otherwise.**
6. Access bolus history on pump	☐ Independent ☐ Needs Assistance	
7. Prepare reservoir and tubing	☐ Independent	
8. Insert infusion set	☐ Independent	
9. Use & programming of square/extended/dual/combo bolus features	☐ Independent ☐ Needs Assistance	
10. Use and programming of temporary basals for exercise and illness	☐ Independent ☐ Needs Assistance	
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	☐ Independent ☐ Needs Assistance	

Institution Form #

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

Institution Name and Address

DIABETES MEDICAL MANAGEMENT PLAN

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

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:

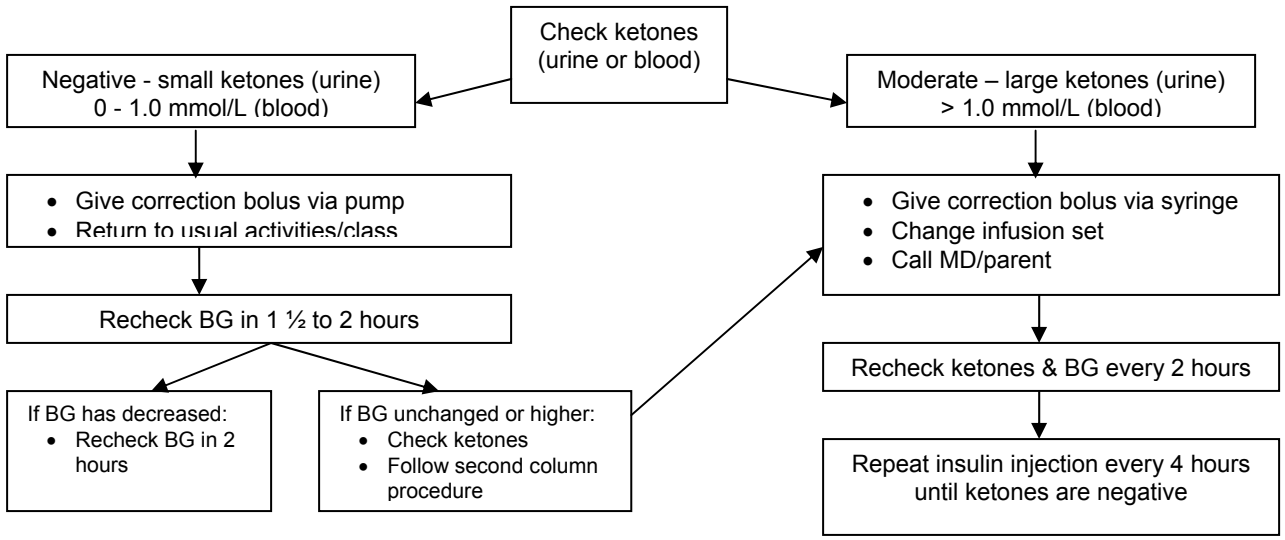
1. **Treat with Glucagon** (See Diabetes Medical Management Plan)
2. **Call 911** (or designate another individual to do so)
3. **Stop insulin pump** by any of the following methods (Send pump with EMS to hospital):
   - Placing in "suspend" or stop mode (See manufacturer's instructions)
   - Disconnecting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

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:



ADDITIONAL TIMES TO CONTACT PARENT/GUARDIAN

- Soreness, redness or bleeding at infusion site
- Leakage of insulin at connection to pump or infusion site
- Insulin injection given for high BG/ketones
- Dislodged infusion set
- Pump malfunction
- 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 NAME
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: **2011 - 2012 SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: xxx-xxx-xxxx Office Fax: xxx-xxx-xxxx Date: **1/13/2011**

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 NAME
Institution Address

DEPARTMENT
DIABETES MEDICAL MANAGEMENT PLAN

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

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_____ _____

Parent/Guardian Signature *Date*

_____ _____

Student Signature *Date*

Institution Form #