Virginia School Diabetes Medical Management Forms

Attachment I
Regulation 757-6

Student _____ **School/SACC** _____ **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/childcare contractor (CCC) 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/CCC 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/SACC.
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.

Plan Reviewed and Approved by:

School Principal_____ Date_____

Supervisor of School Health Services_____ 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/CCC 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/CCC 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/CCC 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/CCC personnel that have been trained, please contact the school nurse. Names and training records are kept in the school clinic/SACC office.

Part 2: Virginia Diabetes Medical Management Plan (DMMP)

To be completed by physician/provider.

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

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

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

Student Name (Last, First, MI)	Student's Date of Birth	
School/SACC	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/CCC 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/SACC	_____ mg po	_____ AM or PM	Nausea/vomiting, diarrhea	Clear liquids
☐ Other: _____® ☐ to be administered at school				

Additional Instructions:

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

Attachment I
Regulation 757-6

SCHOOL/SACC YEAR DIABETES SCHOOL/SACC CARE PLAN Student: _____
Intensive Therapy/Multiple Daily Injections Effective Date: _____

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/SACC hours: ☐ Yes ☐ No

☐ May calculate/give own injections with supervision
☐ Requires assistance to calculate/give injections
☐ Independently calculates/gives own injection

☐ 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 < 70 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: **SCHOOL/SACC YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: _____ Office Fax: _____ **Emergency #:_____**

SCHOOL/SACC YEAR DIABETES SCHOOL/SACC 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 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: _____

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 > ___ 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 _____ 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/CCC 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/CCC to contact the health care provider regarding these orders and administration of these medications.

School/SACC plan ordered by:	Physician/Provider Signature: Provider Printed Name:	Date:
Acknowledged and received by:	Parent/Legal Guardian:	Date:
Acknowledged and received by:	School/CCC Representative:	Date:

Institution Form #