

# Virginia School Diabetes Medical Management Forms

Student \_\_\_\_\_ School \_\_\_\_\_ Effective Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_

## Instructions:

- 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).
  - 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.
  - 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.
  - 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.
  - 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

Page 1 of 2

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 # \_\_\_\_\_

Medical History	Parent/Guardian Response (check appropriate boxes and complete blanks)				
Diagnosis information	At what age? _____ Type of diabetes? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other _____				
Allergies (include foods, medications, etc.)					
How often is child seen by diabetes healthcare provider?	Frequency: _____		Date of last visit: _____		
Nutritional needs  <input type="checkbox"/> <b>Gluten Free</b>	♦ Snacks <input type="checkbox"/> ___AM <input type="checkbox"/> ___PM <input type="checkbox"/> ___Prior to Exercise/Activity <input type="checkbox"/> Only in case of low blood glucose <input type="checkbox"/> Student may determine if CHO counting <input type="checkbox"/> In the event of a class party may eat the treat (include insulin coverage if indicated in medical orders) <input type="checkbox"/> student able to determine whether to eat the treat <input type="checkbox"/> replace with parent supplied treat <input type="checkbox"/> may NOT eat the treat ♦ Other _____				
Child's most common signs of low blood glucose	<input type="checkbox"/> trembling	<input type="checkbox"/> tingling	<input type="checkbox"/> loss of coordination		
	<input type="checkbox"/> dizziness	<input type="checkbox"/> moist skin/sweating	<input type="checkbox"/> slurred speech		
	<input type="checkbox"/> heart pounding	<input type="checkbox"/> hunger	<input type="checkbox"/> confusion		
	<input type="checkbox"/> weakness	<input type="checkbox"/> fatigue	<input type="checkbox"/> seizure		
	<input type="checkbox"/> pale skin	<input type="checkbox"/> headache	<input type="checkbox"/> unconsciousness		
	<input type="checkbox"/> change in mood or behavior	<input type="checkbox"/> other _____			
How often does child experience low blood glucose and how severe?	<b>Mild/Moderate</b> <input type="checkbox"/> once a day <input type="checkbox"/> once a week <input type="checkbox"/> once a month Indicate date(s) of last mild/moderate episode(s) _____ What time of day is most common for hypoglycemia to occur? _____ <b>Severe</b> (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? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Yes, if available				
Illness/hospitalizations in the last year	Date(s) and describe: _____				
List any other medications currently being taken	<b>Name of Medication</b>	Dose	When to give	Oral / Injection	Duration
Other concerns & 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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Effective Date: \_\_\_\_\_

## Virginia School Diabetes Medical Management Plan (DMMP) Part 1 Contact Information and Medical History

**Virginia Diabetes Council - School Diabetes Care Practice and Protocol** - Provides guidelines, recommended accommodations and references applicable to all students with diabetes. This document is electronically available: <http://www.virginiadiabetes.org>

**Instructions:** Parent / Guardian to complete form. Thank you.

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Homeroom Teacher: \_\_\_\_\_ Effective Date : \_\_\_\_\_

**Parent/Guardian #1:**

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

**Parent/Guardian #2:**

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

**Other emergency contact:**

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

**Physician/ Health Care Provider:**

**Certified Diabetic Educator:**

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Required by Virginia Law:**

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

Parent authorization for trained school designees to administer:

INSULIN  Yes  No

GLUCAGON  Yes  No

I 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 my endocrinologist and members of the diabetes management team regarding my child's diabetes should the need arise.

\*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.

**Parent / Guardian Name / Signature :** \_\_\_\_\_ **Date:** \_\_\_\_\_

**School Nurse Name / Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Medical History	Parent/Guardian Response (check appropriate boxes and complete blanks)				
Diagnosis information	At what age? _____ Type of diabetes? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other _____				
Allergies (include foods, medications, etc.)					
How often is child seen by diabetes healthcare provider?	Frequency: _____		Date of last visit: _____		
Nutritional needs  <input type="checkbox"/> <b>Gluten Free</b>	♦ Snacks <input type="checkbox"/> ___AM <input type="checkbox"/> ___PM <input type="checkbox"/> ___Prior to Exercise/Activity <input type="checkbox"/> Only in case of low blood glucose <input type="checkbox"/> Student may determine if CHO counting <input type="checkbox"/> In the event of a class party may eat the treat (include insulin coverage if indicated in medical orders) <input type="checkbox"/> student able to determine whether to eat the treat <input type="checkbox"/> replace with parent supplied treat <input type="checkbox"/> may NOT eat the treat ♦ Other _____				
Child's most common signs of low blood glucose	<input type="checkbox"/> trembling	<input type="checkbox"/> tingling	<input type="checkbox"/> loss of coordination		
	<input type="checkbox"/> dizziness	<input type="checkbox"/> moist skin/sweating	<input type="checkbox"/> slurred speech		
	<input type="checkbox"/> heart pounding	<input type="checkbox"/> hunger	<input type="checkbox"/> confusion		
	<input type="checkbox"/> weakness	<input type="checkbox"/> fatigue	<input type="checkbox"/> seizure		
	<input type="checkbox"/> pale skin	<input type="checkbox"/> headache	<input type="checkbox"/> unconsciousness		
	<input type="checkbox"/> change in mood or behavior	<input type="checkbox"/> other _____			
How often does child experience low blood glucose and how severe?	<b>Mild/Moderate</b> <input type="checkbox"/> once a day <input type="checkbox"/> once a week <input type="checkbox"/> once a month Indicate date(s) of last mild/moderate episode(s) _____ What time of day is most common for hypoglycemia to occur? _____ <b>Severe</b> (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? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Yes, if available				
Illness/hospitalizations in the last year	Date(s) and describe: _____				
List any other medications currently being taken	<b>Name of Medication</b>	Dose	When to give	Oral / Injection	Duration
Other concerns & comments					

Supplies to bring to school:	
<ul style="list-style-type: none"> <li>• Glucose meter, testing strips, lancets, and batteries for the meter</li> <li>• Urine and/or blood ketone test strips and meter</li> <li>• Insulin(s), syringes, and/or insulin pen(s) and supplies</li> <li>• Insulin pump and supplies, including syringes, pen(s), and insulin(s) in case of pump failure</li> </ul>	<ul style="list-style-type: none"> <li>• Carbohydrate-containing snacks, such as whole grain crackers, dried fruit or yogurt</li> <li>• Hypoglycemia treatment supplies; quick-acting glucose and carbohydrate snacks</li> <li>• Water</li> <li>• Glucagon emergency kit</li> <li>• Antiseptic wipes or wet wipes</li> <li>• Other medications</li> </ul>

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Effective Date: \_\_\_\_\_

## Virginia School Diabetes Medical Management Plan (DMMP) Part 2

**Notice to Parent(s) / Guardian(s):**

Medication(s) must be brought to school appropriately labeled by the pharmacy or physician/healthcare provider. In order for schools to safely administer medication in the school setting, the following should be observed:

- A new copy of the DMMP must be completed at the beginning of each school year.
- This form or healthcare provider prescription must be received in order to change diabetes care at school, except for those changes indicated for parent's / guardian's adjustment.
- Trained school personnel may assist child in increasing independence with self-management skills as developmentally appropriate with parental / guardian consent.

**Student's Diagnosis:**

- Type 1 Diabetes     
  Type 2 Diabetes     
  Other \_\_\_\_\_

MONITORING	
<b>Blood Glucose Monitoring</b> With meter, lancets, lancing device, and test strips	<input type="checkbox"/> Yes: <ul style="list-style-type: none"> <li><input type="checkbox"/> Requires assistance to monitor blood glucose</li> <li><input type="checkbox"/> May monitor own blood glucose with supervision</li> <li><input type="checkbox"/> Independently monitors own blood glucose - Refer to page 8 for permission form</li> </ul>
<b>When to check blood glucose</b>	<input type="checkbox"/> Before meals <input type="checkbox"/> For symptoms of hypoglycemia and/or hyperglycemia <input type="checkbox"/> Anytime the student does not feel well <input type="checkbox"/> Before Physical Education Class <input type="checkbox"/> After Physical Education Class <input type="checkbox"/> Additional Blood Glucose monitoring may be performed at parent / guardian's request: _____
<b>Continuous Glucose Monitor</b> <input type="checkbox"/> Yes - Dex Com / Medtronic <input type="checkbox"/> Low limit alarm: _____ <input type="checkbox"/> High limit alarm: _____ <input type="checkbox"/> Parent/Guardian may adjust alarms	<ul style="list-style-type: none"> <li>• Always confirm Continuous Glucose Monitor results with finger stick check before taking action on sensor blood glucose level.</li> <li>• If student has symptoms or signs of hypoglycemia, check blood glucose level by finger stick, regardless of Continuous Glucose Monitor reading.</li> <li>• If sensor is dislodged, do NOT discard, student will bring home.</li> </ul>
<b>Ketone Checking</b> Urine or Blood	<input type="checkbox"/> Yes: Anytime the BG > _____ mg/dL two times in a row, at least one hour apart, or when student complains of nausea, vomiting, abdominal pain (See page 7 for hyperglycemia management)

**EXERCISE AND SPORTS**

A source of fast-acting glucose & glucagon **must** be available in case of hypoglycemia.

Student should **not** exercise for the following reasons:

- His/her blood glucose is < \_\_\_\_\_ mg/dL (refer to page 7 for hypoglycemia management)
- His/her urine ketones are moderate to large (blood ketones >1.0 mmol/L) immediately prior to exercise (See page 8 for hyperglycemia management)

Student can return to exercise when:

- Blood glucose is > \_\_\_\_\_ mg/dL OR
- Urine ketones are trace to small (blood ketones < 0.6 mmol/L - 1.0 mmol/L)

**MEDICATION – (Other than insulin)**

Name	Dose / Route	When to give	Directions
<input type="checkbox"/> Glucagon	<input type="checkbox"/> 0.5 mg intramuscular or subcutaneous  <input type="checkbox"/> 1.0 mg intramuscular or subcutaneous	<ul style="list-style-type: none"> <li>• Unconscious</li> <li>• Semi-conscious</li> <li>• Unable to control his/her airway</li> <li>• Unable to swallow</li> <li style="text-align: center;">AND/OR</li> <li>• Seizing</li> </ul>	<ul style="list-style-type: none"> <li>• Reconstitute per medication instructions</li> <li>• INJECT IMMEDIATELY</li> <li>• Roll student to side-lying position, medication increases vomiting risk</li> <li>• Call 911</li> <li>• Call parent / guardian</li> </ul>
<input type="checkbox"/> Glucophage (Metformin)	<input type="checkbox"/> 500 mg by mouth with food <input type="checkbox"/> 1000 mg by mouth with food		<input type="checkbox"/> To be given at school _____ AM <input type="checkbox"/> To be given at school _____ PM
<input type="checkbox"/> Other			

Healthcare Provider Name / Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**INSULIN**

To be administered subcutaneously by insulin pen; insulin vial and a syringe; or insulin pump  
**ALWAYS** treat hypoglycemia before administration of insulin.

Insulin to be given during school hours:

- Yes:
- Requires assistance to calculate/give injections
  - May calculate/give own injections with supervision
  - Independently calculates/gives own injection - Refer to page 8 for permission form

**INTENSIVE**

**COLUMN A + COLUMN B = TOTAL INSULIN DOSE**

**COLUMN A (CARBOHYDRATE COVERAGE)** = # carbohydrates consumed ÷ carbohydrate ratio

**COLUMN B (CORRECTION DOSE)** = actual blood glucose – target pre-meal blood glucose ÷ correction factor

- When rounding, only round the total insulin dose
- If uneven, then round to the nearest half or whole unit. (for example, total dose = 1.4 units- then give 1.5 units)
- If physical activity follows meal, then may round down. (for example, total dose = 1.4 units – then give 1.0 units)

**DOSING**

INSULIN TYPE	COLUMN A Carbohydrate Coverage		COLUMN B Correction Dose														
<input type="checkbox"/> <u>Rapid Acting Insulin</u> Humalog, Novolog or Apidra  <input type="checkbox"/> <u>Short Acting Insulin</u> Humulin Regular or Novolin Regular  • If carbohydrate intake can be predetermined, insulin should always be given prior to meal/snack • If carbohydrate intake cannot be predetermined, insulin should be given as soon as possible after completion of meal/snack	<input type="checkbox"/> <b>BREAKFAST Carbohydrate Ratio:</b> ___ unit(s) for every ___grams of carbohydrates	<b>PLUS</b>	<input type="checkbox"/> <b>Correction Formula:</b> Actual blood glucose - _____ (target) ÷ _____ (correction factor) = units of insulin  (Add this to carbohydrate coverage, column A)														
	<input type="checkbox"/> <b>LUNCH Carbohydrate Ratio:</b> ___ unit(s) for every ___grams of carbohydrates		OR														
	<input type="checkbox"/> <b>SNACK Carbohydrate Ratio:</b> ___ unit(s) for every ___grams of carbohydrate		<input type="checkbox"/> <b>Follow the correction dose scale below:</b>														
	<input type="checkbox"/> <b>PARENT/GUARDIAN may adjust Carbohydrate Ratio from:</b> ___ unit(s) for every ___grams of carbohydrate <b>to</b> ___ unit(s) for every ___grams of carbohydrate		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">For blood glucose above TARGET _____</th> <th style="width: 50%;">Then add this many units of insulin to carbohydrate coverage, column A</th> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	For blood glucose above TARGET _____	Then add this many units of insulin to carbohydrate coverage, column A												
	For blood glucose above TARGET _____		Then add this many units of insulin to carbohydrate coverage, column A														
<input type="checkbox"/> <b>EXERCISE Carbohydrate Ratio:</b> Per parent/guardian. Follow the carbohydrate ratio range as indicated in " <b>Parent/Guardian carbohydrate ratio</b> "	<input type="checkbox"/> <b>This correction may be used to administer insulin for elevated blood glucose if 3 hours or more since last insulin dose.</b>																

**CONVENTIONAL**

INSULIN TYPE	WHEN	DOSING	
<input type="checkbox"/> <u>Rapid Acting Insulin</u> Humalog, Novolog or Apidra  <input type="checkbox"/> <u>Short Acting Insulin</u> Humulin or Novolin Regular	<input type="checkbox"/> <b>PRE meals for _____ grams of carbohydrate</b>	<b>Blood Glucose</b>	<b>Units of Insulin</b>
		<b>Less than</b>	

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**STUDENT ON INSULIN PUMP - Pump Brand/Model:** \_\_\_\_\_  
 If unable to reach parent/ guardian for pump operation, insulin by injection may be given per DMMP orders.

Student Skills		
1. Count carbohydrates	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
2. Bolus for carbohydrates consumed	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
3. Calculate and administer correction bolus	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
4. Give injection with syringe or pen, if needed	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
5. Disconnect pump	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
6. Reconnect pump at infusion set	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
7. Access bolus history on pump	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
8. Prepare reservoir and tubing	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian
9. Insert infusion set	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian
10. Use & programming of square/extended/dual/combo bolus features	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian
11. Use and programming of temporary basal for exercise and illness	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian
12. Re-program pump settings if needed	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian
13. Trouble shoot alarms and malfunctions, i.e. change insulin pump batteries	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian

Additional Times to contact the parent / guardian

<ul style="list-style-type: none"> <li>• Dislodged infusion set</li> <li>• Pump malfunction</li> <li>• Repeated alarms</li> </ul>	<ul style="list-style-type: none"> <li>• Insulin injection given for high blood glucose and / or ketones</li> <li>• Leakage of insulin at connection to pump or infusion site.</li> <li>• Soreness, redness or bleeding at infusion site</li> </ul>
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**LONG ACTING INSULIN**  
 To be given during school hours  
 AND / OR  
 For extended day, overnight field trips, unplanned disaster / emergency (72 hours)

Insulin Type	WHEN TO GIVE	CURRENT DOSE - To be confirmed prior to extended day or overnight field trip event	
		<input type="checkbox"/> Humulin NPH OR Novolin NPH <input type="checkbox"/> Lantus <input type="checkbox"/> Levemir <input type="checkbox"/> Other _____	<input type="checkbox"/> To be given during school hours <input type="checkbox"/> To be given for extended day, overnight field trip, unplanned disaster or emergency

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Effective Date: \_\_\_\_\_

## Hypoglycemia Management (Low Blood Glucose)

If hypoglycemia is suspected, check the blood glucose level with finger check.

**Hypoglycemia (Low Blood Glucose): Any blood sugar below \_\_\_\_\_ mg / dL. Signs may include:**

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatigue	Irritable	Crying
Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure

**Refer to page 2 for patient specific signs and symptoms**

### **Mild to Moderate Hypoglycemia:**

Blood glucose is < \_\_\_\_\_ mg / dL and student is conscious and able to swallow

1. Immediately give 15 grams fast-acting carbohydrate (example - 3-4 glucose tablets; 4 ounces of regular soda/juice or one small tube glucose/cake gel)
2. Repeat blood glucose check in 15 minutes
3. If blood glucose still < \_\_\_\_\_ mg / dL, then re-treat with 15 grams of fast-acting carbohydrates and repeat blood glucose in 15 minutes.
4. Once blood glucose is > \_\_\_\_\_ mg / dL
  - If at lunch or snack time, let student eat and cover carbohydrate per orders
  - If not at lunch or snack time, provide student slowly-released carbohydrate snack (example: 3-4 peanut butter crackers, 3-4 cheese crackers or ½ sandwich)
  - Resume normal activity
5. **If unable to raise blood glucose above \_\_\_\_\_ mg / dL after providing 3 treatments with fast acting glucose**
  - Call parent/guardian
  - If unable to reach parent/guardian, call Health Care Provider
  - If unable to reach Health Care Provider, **call 911**

### **Severe Hypoglycemia:**

If student is unconscious, semi-conscious, unable to control his/her airway, unable to swallow and/or seizing

1. Reconstitute glucagon per medication instructions
2. Administer glucagon intramuscularly
3. Roll student to side-lying position as medication increases risk for vomiting
4. **Call 911** for emergency assistance
5. Call parent/guardian
6. **If on INSULIN PUMP, Stop insulin pump** by any of the following methods:
  - Place pump in “suspend” or “stop mode” (See manufacturer’s instructions)
  - Disconnect at site
  - Cut tubing
  - **ALWAYS** send pump with EMS to hospital

Healthcare Provider Name / Signature \_\_\_\_\_ Date \_\_\_\_\_



Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Effective Date: \_\_\_\_\_

## Hyperglycemia Management (High Blood Glucose)

If hyperglycemia is suspected, check the blood glucose level with finger check.

**Hyperglycemia (High Blood Glucose):** Any blood sugar above \_\_\_\_\_ mg / dL. Signs may include:

Extreme thirst	Frequent urination	Blurry Vision	Hunger	Headache
Nausea	Hyperactivity	Irritable	Dizziness	Stomach ache

**Refer to page 2 for patient specific signs and symptoms**

### **If hyperglycemia is suspected**

1. Check the blood glucose level with finger check.
2. Encourage student to drink fluids, 8 oz of water when hyperglycemia is present.

**If blood glucose is > \_\_\_\_\_ mg/dL** - two times in a row, at least one hour apart, and / or when student complains of nausea, vomiting, or abdominal pain –

1. Check ketones
2. **If unable to check ketones:**
  - Give 8 oz of water and retest blood glucose in 1 hour
  - If student complains of nausea, vomiting, or abdominal pain, call parent to pick up the student
  - If student exhibiting emergency symptoms (see below), **call 911**

### **If urine ketones are negative to small (blood ketones < 0.6 mmol/L - 1.0 mmol/L)**

1. Give 8-16 ounces of water
2. If insulin has not been administered within 3 hours, provide correction insulin according to student's correction factor and target pre-meal blood glucose (see page 4)
3. Return student to his / her classroom
4. Recheck blood glucose and ketones in 3 hours after administering insulin

### **If urine ketones are moderate to large (blood ketones >1.0 mmol/L)**

1. Call parent/guardian
2. If unable to reach parent/guardian, call Health Care Provider
3. Give 8-16 ounces of water
4. If insulin has not been administered within 3 hours, provide correction insulin according to student's correction factor and target pre-meal blood glucose (see page 4)
5. If unable to reach parent/guardian or Health Care Provider, **call 911**
6. **IF ON INSULIN PUMP:**  
Follow the above instructions, plus give insulin correction by insulin vial and syringe and / or insulin pen, not by insulin pump bolus.
7. **HYPERGLYCEMIA EMERGENCY** For students with large ketones and the below symptoms
  - Depressed level of consciousness
  - Increasing sleepiness or lethargy
  - Heavy breathing or shortness of breath
  - **Call 911**

Healthcare Provider Name / Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**PERMISSION TO BE INDEPENDENT**

**Permission for student to independently monitor blood glucose on a school bus, school property, or at a school sponsored activity.**

**Permission for student to independently calculate and administer insulin on a school bus, school property, or at a school sponsored activity.**

- My child has been instructed in and understands his/her diabetes self-management. My child understands that he/she is responsible and accountable for carrying and using his/her medication and equipment and for proper disposal of supplies.
- 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 student's physician / diabetes management team regarding my child's diabetes care (authorization required if contact is other than the school nurse).

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

I have assessed this student and agree the he / she is capable to be independent as noted above. It is understood that I may revoke permission to possess and self-administer said diabetes medication at any point during the school year if it is determined that he / she has abused the privilege of possession and self-administration or if he / she is not safely and effectively self-administering the medication.

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO TREAT AND ADMINISTER MEDICATION  
FOR THE ABOVE  
VIRGINIA SCHOOL DIABETES MANAGEMENT PLAN**

My signature below provides authorization for the Virginia Diabetes Medical Management Plan contained herein. I/We understand that all treatments and procedures may be performed by the school nurse, the student, and/or trained, unlicensed designated school personnel as allowed by school policy or by Emergency Medical Services in the event of loss of consciousness or seizure.

I also give permission for the school and school nurse to contact the health care provider regarding these orders and administration of these medications.

Parent / Guardian Name	Signature	Date
School Representative Name	Signature	Date
Healthcare Provider Name	Signature	Date