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

Institution Form #