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.