

Name: _____ DOB: _____ Date: _____ School Year: _____

Virginia Diabetes Medical Management Plan (DMMP) – Supplement

☐ Adjustable Bolus Insulin Therapy:

Apidra (glulisine), Novolog (aspart), Humalog (lispro), Fiasp (aspart), Admelog (lispro). Brands are interchangeable.

When to give insulin:	INSULIN to CARBOHYDRATE +	INSULIN to CARBOHYDRATE Only	Correction only
	Correction		
Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snack AM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snack PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

☐ INSULIN to CARBOHYDRATE Dose Calculation

Total Grams of Carbohydrate to Be Eaten
"B" Insulin-to-Carbohydrate Ratio X "A" Units of Insulin = _____ Units of Insulin

	"A" Units of Insulin	"B" Insulin-to-Carbohydrate Ratio
<input type="checkbox"/> Breakfast	_____ unit of insulin	Per _____ gm of carbohydrate
<input type="checkbox"/> Lunch	_____ unit of insulin	Per _____ gm of carbohydrate
<input type="checkbox"/> Snack AM	_____ unit of insulin	Per _____ gm of carbohydrate
<input type="checkbox"/> Snack PM	_____ unit of insulin	Per _____ gm of carbohydrate

☐ CORRECTION Dose Calculation (For Elevated blood sugar and ≥ 3 hours since last insulin dose)

<u>Current Blood Glucose – "C" Target Blood Glucose</u> "D" Correction Factor X "E" Units of insulin = _____ Units of Insulin		
"C" Target Blood Glucose	"D" Correction Factor	"E" Units of insulin
_____	_____	<input type="checkbox"/> 0.5 unit
		<input type="checkbox"/> 1.0 unit

OR

☐ CORRECTION Dose Scale ((For Elevated blood sugar and ≥ 3 hours since last insulin dose. Use instead of calculation above to determine insulin correction dose)

Blood Glucose	Insulin Dose
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units

☐ Fixed Insulin dose change:

☐ Long-Acting Insulin dose change:

☐ Other Changes:

This Diabetes Medical Management Plan has been approved by:

Parent / Guardian Name / Signature:	Date:
School representative Name / Signature:	Date:
Student's Physician / Health Care Provider Name / Signature:	Date: