AUBURN UNION SCHOOL DISTRICT
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DIABETES MEDICAL MANAGEMENT PLAN (DMMP)

Dear Parent/Guardian: In order to manage your child's diabetes at school, Part I (Physician section) and Part II (Parent section) of this form must be completed and returned to the district nurse. If you have any questions, please contact Jenny Serrano, District Nurse (jserrano@auburn.k12.ca.us)

Student Name:		Date of Birth
School:	Grade:	School Year:
Date of diabetes diagnosis:		☐Type 1 ☐Type 2 ☐Other:

PART I: To be completed by your primary health care provider

CHECKING BLOOD GLUCOSE			
Brand/model of blood glucose meter:			
Target range of blood glucose:	*Before meals:* ☐90–130 mg/dL ☐Other: _____		
Check blood glucose level:	☐Before breakfast ☐After breakfast ☐____ Hours after breakfast ☐ 2 hours after a correction dose	☐Before lunch ☐After lunch ☐ ____ Hours after lunch ☐Before dismissal ☐As needed for signs/symptoms of illness	☐Mid-morning ☐Before PE ☐After PE ☐Other: _____ ☐As needed for signs/symptoms of low or high blood glucose
Preferred site of testing:	☐Side of fingertip **Note**: *The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.* ☐Other:		
Student's self-care blood glucose checking skills:	☐Independently checks own blood glucose ☐May check blood glucose with supervision ☐Requires a school nurse or trained diabetes personnel to check blood glucose ☐Uses a smartphone or other monitoring technology to track blood glucose values		

CONTINUOUS GLUCOSE MONITOR (CGM)	
Continuous glucose monitor (CGM):	☐ Yes Brand/model: _____ ☐ No
	Alarms set for: ☐Severe Low: _____ Low: _____ High: _____ ☐Predictive alarm: Low: _____ High: _____ ☐Rate of change: Low: _____ High: _____ ☐Threshold suspend setting: _____

CGM (continued)			
Additional Information for Student with CGM ☐ Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level. If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM. ☐ Insulin injections should be given at least three inches away from the CGM insertion site. ☐ Do not disconnect from the CGM for sports activities.			
Student's Self-care CGM Skills	**Independent?**		
The student troubleshoots alarms and malfunctions.	☐ Yes	☐ No	☐ W/Supervision
The student knows what to do and is able to deal with a HIGH alarm.	☐ Yes	☐ No	☐ W/Supervision
The student knows what to do and is able to deal with a LOW alarm.	☐ Yes	☐ No	☐ W/Supervision
The student can calibrate the CGM	☐ Yes	☐ No	☐ W/Supervision
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ Yes	☐ No	☐ W/Supervision

The student should be escorted to the nurse if the CGM alarm goes off? ☐ Yes ☐ No

HYPOGLYCEMIA (LOW BLOOD GLUCOSE)		
Student's usual symptoms of hypoglycemia:		
If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL:	☐ Give a quick-acting glucose product equal to _____ grams of carbohydrate.	☐Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.
	☐Additional Treatment:	

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):	• Position the student on his or her side to prevent choking.
	• Give glucagon:
	  ○ ☐1 mg ☐½ mg ☐Other (dose) _____
	• Route:
	  ○ ☐Subcutaneous (SC) ☐Intramuscular (IM)
	• Site for glucagon injection:
	  ○ ☐Buttocks ☐Arm ☐Thigh ☐Other: _____
	• Call 911 (Emergency Medical Services) and the student's parents/guardians.	

Call parent if blood glucose below:	_____ mg/dL	

HYPERGLYCEMIA (HIGH BLOOD GLUCOSE)	
Student's usual symptoms for hyperglycemia:	
If exhibiting symptoms of hyperglycemia, OR if blood glucose level is more than _____ mg/dL:	☐Check urine ketones if blood glucose over _____mg/dL ☐For blood glucose greater than _____ mg/dL AND at least ____ hours since last insulin dose, give correction dose of insulin (see correction dose orders). ☐Notify parents/guardians if blood glucose is over _____ mg/dL. ☐Allow unrestricted access to the bathroom. ☐Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour ☐Follow physical activity and sports orders

HYPERGLYCEMIA continued	
	For insulin pump users: see *Additional Information for Student with Insulin Pump.*
Hyperglycemic emergency:	If the student has symptoms of a hyperglycemia emergency, call 911 and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: • dry mouth • extreme thirst • nausea and vomiting • severe abdominal pain • heavy breathing or shortness of breath • chest pain, increasing sleepiness or lethargy • depressed level of consciousness.

INSULIN THERAPY	
Insulin delivery device:	☐Syringe ☐Insulin pen ☐Insulin pump
Type of insulin therapy at school:	☐Adjustable (basal-bolus) insulin ☐Fixed insulin therapy ☐No insulin
Type of insulin:	☐Novolog ☐ Humalog ☐Apidra ☐Other:
Meal time insulin dose to be given pre-meal unless alternative checked:	☐Post-meal ☐either pre- or post-meal

Student's self-care insulin administration skills	**Independent?**		
Student can perform own blood glucose checks	☐ Yes	☐ No	☐W/Supervision
Student can calculate carbohydrates independently	☐ Yes	☐ No	☐W/Supervision
Student can determine correct amount of insulin	☐ Yes	☐ No	☐W/Supervision
Student can draw correct dose of insulin	☐ Yes	☐ No	☐W/Supervision
Student can give own injections	☐ Yes	☐ No	☐W/Supervision
Student can bolus correctly (for carbs or for correction of hyperglycemia)	☐ Yes	☐ No	☐W/Supervision

Before school meal	**Lunch**	**After school meal**
Insulin dose = _____units Insulin dose = _____units/_____grams of carbohydrates	Insulin dose = _____units Insulin dose = _____units/_____grams of carbohydrates	Insulin dose = _____units Insulin dose = _____units/_____grams of carbohydrates
Sliding Scale: (DO NOT USE IF WITHIN 3 HOURS OF PREVIOUS INSULIN DOSE).		
___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl **Sliding scale is based on correction factor of ____units/_____ mg/dl blood sugar.**	___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl **Sliding scale is based on correction factor of ____units/_____ mg/dl blood sugar.**	___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl ___units if blood glucose is____to____mg/dl **Sliding scale is based on correction factor of ____units/_____ mg/dl blood sugar.**

INSULIN THERAPY continued
☐ Yes ☐ No Parents/guardians authorization should be obtained before administering a correction dose. ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/– _____ units of insulin. ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/– _____ grams of carbohydrate. ☐ Yes ☐ No Parents/guardians are authorize to increase or decrease fixed insulin dose within the following range: +/– _____ units of insulin.
☐Use this dose if insulin is used to cover snacks: Insulin dose = _____units/____grams carb. ☐Do not use insulin to cover snacks.

ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP	
Brand/model of pump:	**Type of insulin in pump:**
Basal rates during school:	_____units/hr. _____to_____ _____units/hr. _____to_____ _____units/hr. _____to_____
Insulin/carbohydrate ratio:	
Correction factor:	
Other pump instructions:	
Type of infusion set:	
Appropriate infusion site(s):	
Troubleshooting:	☐For blood glucose greater than _____ mg/dL that has not decreased within ____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians. ☐For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen. ☐For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.
Physical Activity:	May disconnect from pump for sports activities: ☐Yes, for ____ hours ☐No Set a temporary basal rate: ☐Yes, for ____ hours ☐No Suspend pump use: ☐Yes, for ____ hours ☐No

Student's Self-Care Pump Skills	**Independent?**		
Counts carbohydrates	☐ Yes	☐ No	☐W/Supervision
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No	☐W/Supervision
Administers correction bolus	☐ Yes	☐ No	☐W/Supervision
Calculates and sets basal profiles	☐ Yes	☐ No	☐W/Supervision
Calculates and sets temporary basal rate	☐ Yes	☐ No	☐W/Supervision
Changes batteries	☐ Yes	☐ No	☐W/Supervision

Student's Self-Care Pump Skills (con't)	Independent?		
Disconnects pump	☐ Yes	☐ No	☐W/Supervision
Reconnects pump to infusion set	☐ Yes	☐ No	☐W/Supervision
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No	☐W/Supervision
Inserts infusion set	☐ Yes	☐ No	☐W/Supervision
Troubleshoots alarms and malfunctions	☐ Yes	☐ No	☐W/Supervision

OTHER DIABETES MEDICATIONS			
Name:	Dose:	Route:	Times Given:
Name:	Dose:	Route:	Times Given:

MEAL PLAN		
Meal/Snack	Time	Carb Content (grams)
Breakfast		_____to_____
Mid-morning snack		_____to_____
Lunch		_____to_____
Mid-afternoon snack		_____to_____

Other times to give snacks and content/amount:

_____

Instructions for when food is provided to the class (e.g. as part of a class party or food sampling event):

_____

Special event/party food permitted: ☐Parents'/Guardians' discretion ☐Student discretion

PHYSICAL ACTIVITY AND SPORTS	
A quick-acting source of glucose such as:	☐Glucose tabs and/or ☐sugar-containing juice must be available at the site of physical education activities and sports.
Student should eat:	☐15 grams ☐30 grams of carbohydrate ☐ other: _____
Time:	☐Before ☐Every 30 minutes during ☐Every 60 minutes during ☐After vigorous physical activity ☐Other: _____
NOTE:	• If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL. • Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

DISASTER PLAN	
To prepare for an unplanned disaster or emergency (72 hours):	☐Obtain emergency supply kit from parents/guardians. ☐Continue to follow orders contained in this DMMP. ☐Additional insulin orders as follows (e.g., dinner and nighttime): _____ _____ _____ _____ ☐Other: _____

SUPPLIES TO BE KEPT AT SCHOOL (provided by parent/guardian)			
Needed?	**SUPPLIES**	**Date Checked In**	**Exp Date of Items**
	Blood glucose meter, blood glucose test strips, batteries for meter		
	Lancet device, lancets, gloves, etc.		
	Fast acting source of glucose		
	Insulin vials and syringes		
	Carbohydrate containing snack		
	Insulin pump and supplies		
	Insulin pen, pen needles, insulin cartridges		
	Urine/blood ketone strips		
	Glucagon emergency kit		

HEALTHCARE PROFESSIONAL AUTHORIZATION
My signature below provides authorization for the above Diabetes Medical Management Plan. I understand that all procedures will be implemented in accordance with *Education Code section 49423.5.* I understand that specialized physical health care services maybe performed by unlicensed designated school personnel under the training and supervision provided by a school nurse. I also understand that the administration of insulin may be administered by volunteer unlicensed personnel or other volunteers (written) in a non-emergency situation, family members or students themselves. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization(may be faxed).
Provider's Name: **Date:**
Provider's Signature:
Address:
Phone:

PART II: To be completed by parent/guardian

PARENTAL/GUARDIAN AUTHORIZATION
We (I), the undersigned, the parent(s)/ guardian(s) of the above named child, request that this Diabetes Medical Management Plan, and any modifications thereto, be implemented while our (my) child is at school or attending a school-related event on or off campus. We (I) understand that the services will be administered to our (my) child in accordance with *Education Code section 49423.5*. We (I) understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by a school nurse. We (I) also understand that the administration of insulin may be administered by unlicensed volunteer personnel in a non-emergency situation, family members or students themselves. We (I) agree to: 1. Provide the necessary supplies and equipment. 2. Notify the school nurse if there is a change in pupil health status or attending physician. 3. Notify the school nurse immediately and provide new written consent for any changes in the physician's orders. I understand that I will be provided with a copy of my child's completed Diabetes Medical Management Plan. We (I) authorize the school nurse to communicate with the physician when necessary. We (I) also consent to the release of information contained in the Diabetes Medical Management Plan to Auburn Union School District staff 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. This consent also extends to other adults who may need to know the information contained in this Diabetes Medical Management Plan to maintain my child's health and safety. We (I) agree that school personnel implementing this Diabetes Medical Management Plan are authorized to make modifications to the Plan pursuant to written direction from the student's legal parent/guardian. However, we (I) understand that any written parent/guardian consent for modifications that require physician authorization, as noted above, will not be implemented unless written physician authorization is also submitted to school personnel. All modifications to the Diabetes Medical Management Plan MUST be in written form. The requests for modification received in writing must include the date, the modification, and signatures of both the parent/guardian and the school employee receiving them, and a written physician authorization if required. These changes will be attached to this Diabetes Medical Management Plan and will be maintained in the student's health record.
Parent/Guardian Name: **Date:**
Parent/Guardian Signature:

Reviewed and Approved by District Nurse:_____ **Date:** _____

Principal's Signature:_____ **Date**_____