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# PLAN DE MANEJO MÉDICO DE LA DIABETES (PMMD)

**Estimado Padre/Tutor: A fin de poder controlar la diabetes de su hijo en la escuela, se deben completar la Parte I (Sección de médicos) y la Parte II (Sección de Padres) de este formulario y devolverlo a la enfermera del distrito. Si tiene alguna pregunta, comuníquese con Jenny Serrano, enfermera de distrito (jserrano@auburn.k12.ca.us)**

| | | |
|---|---|---|
| **Nombre del estudiante:** | | **Fecha de nacimiento:** |
| **Escuela:** | **Grado:** | **Año escolar:** |
| **Fecha de diagnóstico de la diabetes:** | | ☐**Tipo 1** ☐**Tipo 2** ☐**Otro:** |

**PARTE I: A completar por su proveedor de atención primaria de salud**

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

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

| CGM (continued) |
|---|
| **Additional Information for Student with CGM**<br>☐ 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.<br>☐ Insulin injections should be given at least three inches away from the CGM insertion site.<br>☐ 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.<br>• Give glucagon:<br>  ○ ☐1 mg ☐½ mg ☐Other (dose) _____<br>• Route:<br>  ○ ☐Subcutaneous (SC) ☐Intramuscular (IM)<br>• Site for glucagon injection:<br>  ○ ☐Buttocks ☐Arm ☐Thigh ☐Other: _____<br>• 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<br>☐For blood glucose greater than _____ mg/dL AND at least ____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).<br>☐Notify parents/guardians if blood glucose is over _____ mg/dL.<br>☐Allow unrestricted access to the bathroom.<br>☐Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour<br>☐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.<br>Symptoms of a hyperglycemia emergency include:<br>• dry mouth<br>• extreme thirst<br>• nausea and vomiting<br>• severe abdominal pain<br>• heavy breathing or shortness of breath<br>• chest pain, increasing sleepiness or lethargy<br>• 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<br>Insulin dose = _____units/_____grams of carbohydrates | Insulin dose = _____units<br>Insulin dose = _____units/_____grams of carbohydrates | Insulin dose = _____units<br>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<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl | ___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl | ___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl<br>___units if blood glucose is____to____mg/dl |
| **Sliding scale is based on correction factor of ____units/_____ mg/dl blood sugar.** | **Sliding scale is based on correction factor of ____units/_____ mg/dl blood sugar.** | **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.<br>☐ Yes ☐ No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/– _____ units of insulin.<br>☐ 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.<br>☐ 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.<br>☐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_____<br>_____units/hr. _____to_____<br>_____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.<br>☐For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.<br>☐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<br>Set a temporary basal rate: ☐Yes, for ____ hours ☐No<br>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<br>☐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<br>☐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.<br>• 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.<br>☐Continue to follow orders contained in this DMMP.<br>☐Additional insulin orders as follows (e.g., dinner and nighttime):<br>_____<br>_____<br>_____<br>_____<br>☐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:** |

**PARTE II: Para ser completado por el padre/tutor**

| AUTORIZACIÓN DE PADRES/TUTORES |
|---|
| Nosotros (Yo), el/los abajo firmante/s, los (el) padre(s)/tutor(es) del niño mencionado anteriormente, solicito/solicitamos que este<br>Plan de Manejo Médico de la Diabetes, y cualquier modificación al mismo, se implementará mientras nuestro (mi) hijo esté en la escuela o asistiendo a un evento relacionado con la escuela dentro o fuera del campus. Nosotros (yo) entendemos/entiendo que los servicios se administrarán a nuestro (mi) hijo, de acuerdo con el Código de Educación sección 49423.5. Nosotros (Yo) entendemos/entiendo que los servicios de atención médica especializada pueden ser realizados por personal escolar designado sin licencia, con capacitación y supervisión provistas por una enfermera de la escuela. Nosotros (Yo) también entiendo/entendemos que la insulina puede ser administrada por personal voluntario, sin licencia. en una situación de no emergencia, por familiares o por los estudiantes mismos.<br>Nosotros (yo) estamos/estoy de acuerdo con:<br>1. Proporcionar los suministros y equipos necesarios.<br>2. Notificar a la enfermera de la escuela si hay un cambio del médico tratante o en el estado de salud del alumno.<br>3. Notificar a la enfermera de la escuela inmediatamente y proporcionar un nuevo consentimiento por escrito para cualquier cambio en las órdenes del médico.<br>Entiendo que se me proporcionará una copia del Plan de manejo médico de la diabetes completo de mi hijo.<br>Nosotros (yo) autorizamos/autorizo a la enfermera de la escuela a comunicarse con el médico cuando sea necesario.<br>Nosotros (yo) también aceptamos/acepto la divulgación de la información contenida en el Plan de manejo médico de la diabetes al personal del Distrito Escolar Auburn Union y otros adultos que estén a cargo de supervisar a mi hijo y que pueden necesitar saber esta<br>información para mantener la salud y seguridad de mi hijo. Este consentimiento también se extiende a otros adultos que puedan necesitar conocer la información contenida en este Plan de manejo médico de la diabetes para mantener la salud y seguridad de mi hijo.<br>Nosotros (yo) estamos/estoy de acuerdo en que el personal de la escuela que implementa este Plan de manejo médico de la diabetes está autorizado a realizar modificaciones al Plan, de acuerdo con las instrucciones escritas del padre/tutor legal del estudiante. Sin embargo, nosotros (yo) entendemos/entiendo que cualquier consentimiento por escrito de los padres/tutores para modificaciones que requieran la autorización del médico, como se indica arriba, no se implementarán a menos que también se presente una autorización médica por escrito al personal de la escuela. Todas las modificaciones al Plan de manejo médico de la diabetes DEBEN estar en forma escrita. Las solicitudes de modificación recibidas por escrito deben incluir la fecha, la modificación y las firmas de los padres/tutores y del empleado de la escuela que las recibe, y una autorización por escrito del médico si es necesario. Estos cambios se adjuntarán a este Plan de manejo médico de la diabetes y se mantendrán en el registro de salud del estudiante. |
| **Nombre del Padre/Tutor:** **Fecha:** |
| **Firma del padre/tutor:** |

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

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