



Pasco County Schools

Diabetes Medical Management Plan for School Year 20____ - 20____

Student's Name: _____	Student ID: _____	DOB: _____	Diabetes Type: _____
Date Diagnosed: <u>Select Month from Pulldown</u> (or fill in here: _____) Year: _____			
School: _____		Grade: _____	Home Room: _____
Parent/Guardian #1: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian #2: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian's E-mail Address: _____			
Diabetes Healthcare Provider: _____		Phone: _____	Fax: _____
Student's Self-Management Skills	Independent	Needs Supervision	Full Support By Trained Staff
Performs Testing and Interprets Blood Glucose/CGM Results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calculates Carbohydrate Grams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determines Insulin Dose for Carbohydrate Intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determines Correction Dose of Insulin for High Blood Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determines insulin dose and self-administer insulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Student allowed to carry diabetes supplies	<input type="checkbox"/>	<i>Students who require no supervision are allowed to carry diabetes supplies and self-administer insulin with written parental and physician authorization, according to Florida Statute 1002.20(3)(j).</i>	

Testing Blood Glucose At School
Test Blood Glucose before administering insulin and as needed for signs/symptoms of high/low blood glucose.
Additional Blood Glucose Testing at school: <input type="checkbox"/> Yes (Time/s): _____ <input type="checkbox"/> Before Exercise <input type="checkbox"/> Before Dismissal OR <input type="checkbox"/> No
Target Range for Blood Glucose: _____ mg/dl to _____

Continuous Glucose Monitors (CGM)
Student uses continuous glucose monitoring system at school: <input type="checkbox"/> Yes OR <input type="checkbox"/> No. Make/Model: _____
Alarms set for: Low _____ mg/dl High _____ mg/dl If sensor falls out at school, notify parent
<input type="checkbox"/> May use CGM reading in place of BG finger stick for calculating correction if CGM reading is between _____ or _____ OR <input type="checkbox"/> No
Students using a continuous glucose monitor must always do fingerstick glucose reading to confirm a low/high blood glucose and/or if symptomatic.

LOW Blood Glucose (HYPO-glycemia) – Test Blood Glucose to Confirm
Does student recognize signs of LOW blood glucose? <input type="checkbox"/> Yes <input type="checkbox"/> No
Student's usual symptoms of hypoglycemia. _____
Management of Low Blood Glucose (below _____ mg/dl) by fingerstick.
1. <u>If student is awake and able to swallow</u> : give _____ grams fast-acting carbohydrates such as: <u>4 oz.</u> fruit juice or non-diet soda or 3-4 glucose tablets or concentrated gel or Other: _____
2. Retest blood glucose 10-15 minutes after treatment. Student remains in clinic during treatment.
3. Repeat the above treatment until blood glucose is over _____ mg/dl.
4. Follow treatment with snack of _____ grams of carbohydrates if more than one hour until next meal/snack or if going to activity.
5. Notify parent when blood glucose is below _____ mg/dl.
6. Delay exercise if blood glucose is below _____ mg/d
If student is unconscious or having a seizure, call 911 immediately and notify parents. Position student on side if possible. If wearing an insulin pump, place pump in suspend/stop mode or disconnect/cut tubing.
<input type="checkbox"/> Glucose gel: One tube administered inside cheek and massaged from outside while waiting or during administration of Glucagon.
<input type="checkbox"/> Glucagon: _____ mg administered by trained staff. <input type="checkbox"/> Baqsimi: _____ mg administered nasally by trained staff.

HIGH Blood Glucose (HYPER-glycemia)	
Does student recognize signs of HIGH blood glucose? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Student's usual symptoms of hyperglycemia: _____	
Management of High Blood Glucose (over _____ mg/dl) <i>Students using a continuous glucose monitor must always do fingerstick glucose reading to confirm a high blood glucose.</i> Refer to the Insulin Administration section below for designated times insulin may be given.	
1. Give water or other calorie-free liquids as tolerated and allow frequent bathroom privileges. 2. Check ketones if blood glucose over _____ mg/dl. 3. Notify parent if ketones positive and/or glucose over _____ mg/dl. If moderate/large ketones notify the parent to pick up the child.	
In addition to steps above for management of <u>high</u> blood glucose, also follow steps below for <u>very high</u> blood glucose over _____ mg/dl.	
4. If unable to reach parents, call diabetes care provider. (Medical orders must be in writing. No verbal orders accepted.) 5. If unable to reach parents or physician stay with student and document changes in status. Call 911 for labored breathing, very weak, confused or unconscious. 6. Retest blood glucose in _____ hours if above _____ mg/dl. 7. Delay exercise if blood glucose is above _____ mg/dl.	

Insulin Administration	
Insulin correction for high blood glucose at school, indicate times: <input type="checkbox"/> Before Breakfast <input type="checkbox"/> Before Lunch <input type="checkbox"/> Other time: _____ May repeat insulin correction dose , if greater than _____ hours since last correction dosing.	
Type of Insulin at school:	<input type="checkbox"/> Humalog <input type="checkbox"/> Novolog <input type="checkbox"/> Apidra <input type="checkbox"/> NPH <input type="checkbox"/> Lantus <input type="checkbox"/> Levemir <input type="checkbox"/> Other: _____
Method of Insulin delivery at school:	<input type="checkbox"/> Pen <input type="checkbox"/> Insulin Pump: Pump will calculate insulin dose. If pump fails, use pen/syringe to administer insulin per sliding scale or correction dose below. Indication of possible pump failure is BG > 250 and moderate or large ketones. <input type="checkbox"/> Syringe

Carbohydrate Insulin Dose		
Insulin for carbohydrates eaten at school, indicate times:		
<input type="checkbox"/> Before Breakfast Give one unit of insulin per _____ grams of carbs	<input type="checkbox"/> Before Lunch Give one unit of insulin per _____ grams of carbs	<input type="checkbox"/> Snack. If, yes, time/s: _____ <input type="checkbox"/> Give one unit of insulin per _____ grams of carbs <input type="checkbox"/> Free Snack _____ grams

High Blood Glucose Correction Dose – Use Insulin Sliding Scale or Equation				
Blood glucose _____ to _____	Insulin Dose = _____ units		Blood glucose _____ to _____	Insulin Dose = _____ units
Blood glucose _____ to _____	Insulin Dose = _____ units		Blood glucose _____ to _____	Insulin Dose = _____ units
Blood glucose _____ to _____	Insulin Dose = _____ units		Blood glucose _____ to _____	Insulin Dose = _____ units
OR Correction dose (Actual BG minus Target BG _____ mg/dL) divided by Correction Factor _____ = Correction Dose				

I hereby authorize the above named physician and Pasco County Schools staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all snacks and supplies are to be furnished/restocked by parent.

Physician's/Mid-Level Practitioner's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

School Health Registered Nurse Signature: _____ Date: _____

Place Office Stamp Here