Pasco County Schools

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

Student's Name: _____	Student ID: ____	DOB: _____	Diabetes Type: _____
Date Diagnosed: Select Month from Pulldown (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	☐	☐	☐
Calculates Carbohydrate Grams	☐	☐	☐
Determines Insulin Dose for Carbohydrate Intake	☐	☐	☐
Determines Correction Dose of Insulin for High Blood Glucose	☐	☐	☐
Determines insulin dose and self-administer insulin	☐	☐	☐
Student allowed to carry diabetes supplies	☐	*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).*	

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: ☐ Yes (Time/s): _____ ☐ Before Exercise ☐ Before Dismissal **OR ▶** ☐ No

Target Range for Blood Glucose: _____ mg/dl to _____

Continuous Glucose Monitors (CGM)

Student uses continuous glucose monitoring system at school: ☐ Yes **OR ▶** ☐ No. Make/Model:

Alarms set for: Low _____ mg/dl High _____ mg/dl ***If sensor falls out at school, notify parent***

☐ May use CGM reading in place of BG finger stick for calculating correction if CGM reading is between _____ or _____ **OR ▶** ☐ 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? ☐ Yes ☐ No

Student's usual symptoms of hypoglycemia. _____

Management of Low Blood Glucose (below _____ mg/dl) by fingerstick.

1. If student is awake and able to swallow: give _____. grams fast-acting carbohydrates such as:
   4 oz. 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.

☐ **Glucose gel:** One tube administered inside cheek and massaged from outside while waiting or during administration of Glucagon.

☐ **Glucagon:** _____ mg administered by trained personnel.

Physician's Signature _____ Date _____

Student's Name: _____ **Student's DOB:** _____

HIGH Blood Glucose (HYPER-glycemia)

Does student recognize signs of **HIGH** blood glucose? ☐ Yes ☐ No

Student's usual symptoms of hyperglycemia:_____

Management of High Blood Glucose (over _____ mg/dl)
Students using a continuous glucose monitor must always do fingerstick glucose reading to confirm a high blood glucose.
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 high blood glucose, also follow steps below for very high 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: ☐ Before Breakfast ☐ Before Lunch ☐ Other time: _____
May **NOT** repeat insulin **correction dose** within _____ hours of a correction dose for high blood glucose.

Type of Insulin at school:	☐ Humalog	☐ Novolog	☐ Apidra	☐ NPH	☐ Lantus	☐ Levemir	☐ Other: ____

Method of Insulin delivery at school:	☐ **Pen** ☐ **Syringe**	☐ **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.**

Carbohydrate Insulin Dose

Insulin for ***carbohydrates*** eaten at school, indicate times:

☐ Before Breakfast Give one unit of insulin per _____ grams of carbs	☐ Before Lunch Give one unit of insulin per _____ grams of carbs	☐ Snack. If, yes, time/s: _____ ☐ Give one unit of insulin per _____ grams of carbs ☐ 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