**** Pasco County Schools

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

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| Student’s Name: | Student ID | | DOB: | | Diabetes Type: |
| Date Diagnosed:  (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).* | | |

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| **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** u  No |
| Target Range for Blood Glucose:  mg/dl to |

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| **Continuous Glucose Monitors (CGM)** |
| Student uses continuous glucose monitoring system at school:  Yes **OR** u  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** u  No |
| ***Students using a continuous glucose monitor must always do fingerstick glucose reading to confirm a low/high blood glucose and/or if symptomatic.*** |

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| **LOW Blood Glucose (HYPO-glycemia)** – Test Blood Glucose to Confirm |
| Does student recognize signs of **LOW** blood glucose?  Yes or  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:   1. Retest blood glucose 10-15 minutes after treatment. Student remains in clinic during treatment. 2. Repeat the above treatment until blood glucose is over  mg/dl. 3. Follow treatment with snack of  grams of carbohydrates if more than one hour until next meal/snack or if going to activity. 4. Notify parent when blood glucose is below **\_\_\_** mg/dl. 5. 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 \_\_\_\_\_\_\_\_\_\_  Page 1 of 2

**Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s DOB: \_\_\_\_\_\_\_\_\_\_\_**

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| **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**.   1. If unable to reach parents, call diabetes care provider. (Medical orders must be in writing. No verbal orders accepted.) 2. 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. 3. Retest blood glucose in  hours if above  mg/dl. 4. 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 x | | 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.** | | | | | | |

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| **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 |

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| **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 School’s 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 protect and secure 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 supplies are to be furnished/restocked by parent(s)/guardian. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent’s Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district’s resources identifying my rights (including the notices located at**

[**https://www.pasco.k12.fl.us/ssps/page/parent\_notices**](https://www.pasco.k12.fl.us/ssps/page/parent_notices)**, and pursuant to the Parent’s Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent are indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.**

**Physician’s/Mid-Level Practitioner’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School Health Registered Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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