



Pasco County Schools
Diabetes Medical Management Plan for School Year 20_____ - 20_____

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	<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: 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 or No

Student's usual symptoms of hypoglycemia.

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

- 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: _____
- Retest blood glucose 10-15 minutes after treatment. Student remains in clinic during treatment.
- Repeat the above treatment until blood glucose is over _____ mg/dl.
- Follow treatment with snack of _____ grams of carbohydrates if more than one hour until next meal/snack or if going to activity.
- Notify parent when blood glucose is below _____ mg/dl.
- 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 by subcutaneous or intramuscular injection
- Baqsimi Nasal Spray: 3 mg**
- Gvoke HypoPen:** _____ mg by subcutaneous injection **Gvoke PFS:** _____ mg by subcutaneous injection
- Gvoke Kit (1mg/0.2ml)** by subcutaneous injection

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 administration at school, indicate times: Before Breakfast Before Lunch Snack High Blood Glucose Correction
Insulin correction dose for high blood glucose greater than _____ mg/dl **AND** at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose below).

Whole unit insulin rounding: If insulin dose comes to **0.1 - 0.4 units round down**. If insulin dose comes to **0.5 - 0.9 units round up**.

Type of Insulin at school: Humalog Novolog Apidra NPH Lantus Levemir 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
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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, 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: _____

Place Office Stamp Here