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	**No Supervision Needed**	**Needs Supervision**
Performs and Interprets Blood Glucose Tests	☐	☐
Calculates Carbohydrate Grams	☐	☐
Determines Insulin Dose for Carbohydrate Intake	☐	☐
Determines Correction Dose of Insulin for High Blood Glucose	☐	☐
Student allowed to carry diabetes supplies, determine insulin dose and self-administer insulin	☐	

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): _______ **OR ▶** ☐ No

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

LOW Blood Sugar (HYPO-glycemia) – Test Blood Sugar to Confirm

Student's Usual Signs and Symptoms			Does student recognize signs of **LOW** blood sugar? ☐ Yes ☐ No			
Low Blood Sugar:	☐ Hungry	☐ Weak/Shaky	☐ Headache	☐ Dizziness	☐ Inattention/confusion	
Very Low Blood Sugar:	☐ Nausea or loss of appetite	☐ Slurred speech	☐ Clamminess or sweating	☐ Blurred vision	☐ Loss of consciousness	☐ Other __

Management of Low Blood Glucose (below __________ mg/dl)

1. If student is awake and able to swallow: give 15 grams fast-acting carbohydrates such as: 4 oz. fruit juice or non-diet soda or 3-4 glucose tablets or concentrated gel or tube frosting or 8 oz. milk 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. Glucagon is stored in _______.

Student's Name: ________

HIGH Blood Sugar (HYPER-glycemia)

Student's Usual Signs and Symptoms	Does the student recognize signs of **HIGH** blood sugar? ☐ Yes ☐ No				
High Blood Sugar:	☐ Increased thirst and/or urination	☐ Tired/drowsy	☐ Blurred vision	☐ Warm, dry or flushed skin	☐ Weakness/ muscle aches
Very High Blood Sugar:	☐ Nausea/ vomiting	☐ Abdominal pain	☐ Extreme thirst	☐ Fruity breath odor	☐ Other: ___

Management of High Blood Glucose (over ___________ mg/dl)

1. Refer to the **Insulin Administration** section below for designated times insulin may be given.
2. Give water or other calorie-free liquids as tolerated and allow frequent bathroom privileges.
3. Check **ketones** if blood glucose over ___________ mg/dl.
4. Notify parent if **ketones** positive and/or glucose over ___________ mg/dl.

In addition to steps above for management of high blood glucose, also follow steps below for very high blood glucose over ___________ mg/dl.

5. If unable to reach parents, call diabetes care provider. (Medical orders must be in writing. No verbal orders accepted.)
6. 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.
7. Retest blood glucose in ________ hours if above ___________ mg/dl.
8. 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.** Note: If B/G ≤ 250 or ≥ 250 and **negative/trace ketones**, pump will prescribe insulin dose. If pump fails, use **pen/syringe** to administer insulin per sliding scale below. Indication of possible pump failure is **BG > 250 and moderate or large ketones.**

High Blood Sugar Correction Dose – Use Insulin Sliding Scale

Blood sugar ___________ to	Insulin Dose = ________ units		Blood sugar ___________ to	Insulin Dose = ________ units
Blood sugar ___________ to	Insulin Dose = ________ units		Blood sugar ___________ to	Insulin Dose = ________ units
Blood sugar ___________ to	Insulin Dose = ________ units		Blood sugar ___________ to	Insulin Dose = ________ units

Carbohydrate Insulin Dose

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

☐ Before Breakfast	☐ Before Lunch	☐ Other time: ________
Give one unit of insulin per ________ grams of carbs..	Give one unit of insulin per ________ grams of carbs	Give one unit of insulin per ________ grams of carbs

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.

Parent/Guardian Signature: ______________________________ **Date:** ______________

Physician's/Mid-Level Practitioner's Signature: ______________________________ **Date:** ______________

School Health Registered Nurse Signature: ______________________________ **Date:** ______________

Place Office Stamp Here