



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 Pull-down</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	No Supervision Needed	Needs Supervision
Performs and Interprets Blood Glucose Tests	<input type="checkbox"/>	<input type="checkbox"/>
Calculates Carbohydrate Grams	<input type="checkbox"/>	<input type="checkbox"/>
Determines Insulin Dose for Carbohydrate Intake	<input type="checkbox"/>	<input type="checkbox"/>
Determines Correction Dose of Insulin for High Blood Glucose	<input type="checkbox"/>	<input type="checkbox"/>
Student allowed to carry diabetes supplies, determine insulin dose and self-administer insulin	<input type="checkbox"/>	<input type="checkbox"/>

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: <input type="checkbox"/> Yes (Time/s): _____	OR <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Low Blood Sugar:	<input type="checkbox"/> Hungry	<input type="checkbox"/> Weak/Shaky	<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Inattention/confusion	
Very Low Blood Sugar:	<input type="checkbox"/> Nausea or loss of appetite	<input type="checkbox"/> Slurred speech	<input type="checkbox"/> Clamminess or sweating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Other _____

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

- 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: _____
- 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 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:	<input type="checkbox"/> Pen	<input type="checkbox"/> Insulin Pump: Pump will calculate insulin dose. Note: If B/G ≤ 250 or ≥ 250 and negative/trace ketones , pump will prescribe insulin dose.
	<input type="checkbox"/> Syringe	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:

<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"/> Other time: _____ Give one unit of insulin per _____ grams of carbs
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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