DIABETES MEDICAL MANAGEMENT PLAN (School Year _____)

Student's Name:._____ Date of Birth: _____ Diabetes D Type 1 : D Type 2 Date of Diagnosis :_____

School Name: _____ Grade_____ Homeroom_____ Plan Effective Date(s):_____

CONTACT INFORMATION

Parent/Guardian #1:_____ Phone Numbers Home_____ Work _____ Cell/Pager_____

Parent/Guardian #2: _____ Phone Numbers Home_____ Work _____ Cell/Pager_____

Diabetes Healthcare Provider _____ Phone Number _____

Other Emergency Contact _____ Relationship____ Phone Numbers home _____ Work/Cell/Pager _____

EMERGENCY NOTIFICATION: Notify parents of the following conditions *(If unable to reach parents, call Diabetes Healthcare Provider listed above)*

a. Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.
b. Blood sugars in excess of _____ mg/dl
c. Positive urine ketones.
d. Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, or altered level of consciousness. _____

MEALS/SNACKS: Student can: D Determine correct portions and number of carbohydrate serving D Calculate carbohydrate grams accurately

	Time/Location	Food Content and Amount		Time/Location	Food Content and Amount
D Breakfast	_____	_____	D Mid-afternoon	_____	_____
D Midmorning	_____	_____	D Before PE/Activity	_____	_____
D Lunch	_____	_____	D After PE/Activity	_____	_____

If outside food for party or food sampling provided to class _____

BLOOD GLUCOSE MONITORING AT SCHOOL: D Yes D No Type of Meter: _____

If yes, can student ordinarily perform own blood glucose checks? D Yes D No Interpret results D Yes D No Needs supervision? D Yes D No

Time to be performed:
- D Before breakfast
- D Midmorning: before snack
- D Before breakfast
- D Dismissal
- D Before PE/Activity Time
- D After PE/Activity Time
- D Mid-afternoon
- D As needed for signs/symptoms of low/high blood glucose

Place to be performed: D Classroom D Clinic/Health Room D Other _____

OPTIONAL: Target Range for blood glucose: _____mg/dl to _____(Completed by Diabetes Healthcare Provider).

INSULIN INJECTIONS DURING SCHOOL: D Yes D No D Parent/Guardian elects to give insulin needed at school

If yes, can student: Determine correct dose? D Yes D No Draw up correct dose? D Yes D No

Give own injection? D Yes D No Needs supervision? D Yes D No

Insulin Delivery: D Syringe/Vial D Pen D Pump (If pump worn, use "Supplemental Information Sheet for Student Wearing an Insulin Pump")

Standard daily insulin at school: D Yes D No

Type Dose: Time to be given:

_____ _____ _____

_____ _____ _____

Correction Dose of Insulin ***for High Blood Glucose:*** D Yes D No

If yes: D Regular D Humalog D Novolog Time to be given:_____

D *Determine dose per sliding scale below (in units):*

Blood sugar:_____ Insulin Dose: _____
Blood sugar:_____ Insulin Dose: _____
Blood sugar:_____ Insulin Dose: _____
Blood sugar:_____ Insulin Dose: _____
Blood sugar:_____ Insulin Dose: _____

D *Use formula:*

(Blood glucose - _____) + _____ = units of insulin

Calculate insulin dose for carbohydrate intake: D Yes D No

If yes, use: D Regular D Humalog D Novolog

_____# unit(s) per _____grams Carbohydrate

D Add carbohydrate dose to correction dose

OTHER ROUTINE DIABETES MEDICATIONS AT SCHOOL: D Yes D No

Name of Medication	Dose	Time	Route	Possible Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EXERCISE, SPORTS, AND FIELD TRIPS

Blood glucose monitoring and snacks as above. Quick access to sugar-free liquids, fast-acting carbohydrates, snacks, and monitoring equipment.

A fast-acting carbohydrate such as _____should be available at the site.

Child should not exercise if blood glucose level is below _____mg/dl OR if_____

SUPPLIES TO BE FURNISHED/RESTOCKED BY PARENT/GUARDIAN: (Agreed-upon locations noted on emergency card/nursing care plan)

D Blood glucose meter/strips/lancets/lancing device D Fast-acting carbohydrate _____ D Insulin vials/syringe

D Ketone testing strips D Carbohydrate-containing snacks D Insulin pen/pen needles/cartridges

D Sharps container for classroom D Carbohydrate free beverage/snack D Glucagon Emergency Kit

MANAGEMENT OF HIGH BLOOD GLUCOSE (over _____mg/dl)

Usual signs/symptoms for this student:

- ☐ Increased thirst, urination, appetite
- ☐ Tiredness/sleepiness
- ☐ Blurred vision
- ☐ Warm, dry, or flushed skin
- ☐ Other_____

Indicate treatment choices:

- ☐ Sugar-free fluids as tolerated_____ mg/dl
- ☐ Check urine ketones if blood glucose over
- ☐ Notify parent if urine ketones positive.
- ☐ May not need snack: call parent
- ☐ See "Insulin Injections: Correction Dose of Insulin for High Blood Glucose"
- ☐ Other _____

MANAGEMENT OF VERY HIGH BLOOD GLUCOSE (over _____. mg/dl)

Usual signs/symptoms for this student

- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Rapid, shallow breathing
- ☐ Extreme thirst
- ☐ Weakness/muscle aches
- ☐ Fruity breath odor
- ☐ Other _____

Indicate treatment choices:

- ☐ Carbohydrate-free fluids if tolerated
- ☐ Check urine for ketones
- ☐ Notify parents per "Emergency Notification" section
- ☐ If unable to reach parents, call diabetes care provider
- ☐ Frequent bathroom privileges
- ☐ Stay with student and document changes in status
- ☐ Delay exercise.
- ☐ Other_____

MANAGEMENT OF LOW BLOOD GLUCOSE (below _____. mg/dl)

Usual signs/symptoms for this child

- ☐ Hunger
- ☐ Change in personality/behavior
- ☐ Paleness
- ☐ Weakness/shakiness
- ☐ Tiredness/sleepiness
- ☐ Dizziness/staggering
- ☐ Headache
- ☐ Rapid heartbeat
- ☐ Nausea/loss of appetite
- ☐ Clamminess/sweating
- ☐ Blurred vision
- ☐ Inattention/confusion
- ☐ Slurred speech
- ☐ Loss of consciousness
- ☐ Seizure
- ☐ Other_____

Indicate treatment choices:

If student is awake and able to swallow,

Give ____grams fast-acting carbohydrate such as:

- ☐ 4oz. Fruit juice or non-diet soda or
- ☐ 3-4 glucose tablets or
- ☐ Concentrated gel or tube frosting or
- ☐ 8 oz. Milk or
- ☐ Other_____

Retest BG 10-15minut.es after treatment

Repeat treatment until blood glucose over 80mg/dl

Follow treatment with snack of _____

if more than 1 hour till next meal/snack or if going to activity

- ☐ Other _____
  _____

IMPORTANT!!

If student is unconscious or having a seizure*, presume the student is having a low blood glucose and:*

Call 911 immediately and notify parents.

- ☐ Glucagon 1/2 mg or 1 mg (circle desired dose) should be given by trained personnel.
- ☐ Glucose gel 1 tube can be administered inside cheek and massaged from outside while awaiting or during administration of Glucagon by staff member at scene.
- ☐ Glucagon/Glucose gel could be used if student has documented low blood sugar and is vomiting or unable to swallow.

Student should be turned on his/her side and maintained in this "recovery" position till fully awake".

SIGNATURES

I/we understand that all treatments and procedures may be performed by the student and/or trained unlicensed assistive personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed this information sheet and agree with the indicated instructions. This form will assist the school health personnel in developing a nursing care plan.

Parent's Signature: _____ Date _____

Physician's Signature_____ Date _____

School Nurse's Signature: _____ Date _____

This document follows the guiding principles outlined by the American Diabetes Association

Revised December 5, 2003

DIABETES MEDICAL MANAGEMENT PLAN SUPPLEMENT FOR STUDENT WEARING INSULIN PUMP
School Year_____

Student Name: _____ Date of Birth _____ Pump Brand/Model:_____

Pump Resource Person: _____ Phone/Beeper._____ (See basic diabetes plan for parent phone*)

Child-Lock On? D Yes D No How long has student worn an insulin pump? _____

Blood Glucose Target Range:_____ Pump Insulin: D Humalog D Novolog D Regular

Insulin: Carbohydrate Ratios:_____

(Student to receive carbohydrate bolus *immediately* before / _____ minutes before eating)

Lunch/Snack Boluses Pre-programmed? D Yes D No Times_____

Insulin Correction Formula for Blood Glucose Over Target:_____

Extra pump supplies furnished by parent/guardian: D infusion sets D reservoirs D batteries D dressings/tape D insulin D syringes/insulin pen

STUDENT PUMP SKILLS	NEEDS HELP?	IF YES, TO BE ASSISTED BY AND COMMENTS:
1. Independently count carbohydrates	D Yes D No	
2. Give correct bolus for carbohydrates consumed.	D Yes D No	
3. Calculate and administer correction bolus.	D Yes D No	
4. Recognize signs/symptoms of site infection.	D Yes D No	
5. Calculate and set a temporary basal rate.	D Yes D No	
6. Disconnect pump if needed.	D Yes D No	
7. Reconnect pump at infusion set.	D Yes D No	
8. Prepare reservoir and tubing.	D Yes D No	
9. Insert new infusion set.	D Yes D No	
10. Give injection with syringe or pen, if needed.	D Yes D No	
11. Troubleshoot alarms and malfunctions.	D Yes D No	
12. Re-program basal profiles if needed.	D Yes D No	

MANAGEMENT OF HIGH BLOOD GLUCOSE ***Follow instructions in basic diabetes medical management plan, but in addition:***

If blood glucose over target range _____hours after last bolus or carbohydrate intake, student should receive a correction bolus of insulin using formula; Blood glucose -_____+_____= _____ units insulin

If blood glucose over 250, check urine ketones

1. **If no ketones,** give bolus by pump and recheck in 2 hours.
2. **If ketones present or _____** , give correction bolus as an **injection** immediately and contact parent/ health care provider

If two consecutive blood glucose readings over 250 (2 hrs or more after first bolus given)

1. Check urine ketones
2. Give correction bolus as an injection
3. Change infusion set.
4. Call parent

MANAGEMENT OF LOW BLOOD GLUCOSE *Follow instructions in Basic Diabetes Care Plan, but in addition:*

If low blood glucose recurs without explanation, notify parent/diabetes provider for potential instructions to suspend pump.

If seizure or unresponsiveness occurs:

1. Call 911 (or designate another individual to do so).
2. Treat with Glucagon (See basic Diabetes Medical Management Plan)
3. Stop insulin pump by:
   - ☐ Placing in "suspend" or stop mode (See attached copy of manufacturer's instructions)
   - ☐ Disconnecting at pigtail or clip (Send pump with EMS to hospital.)
   - ☐ Cutting tubing
4. Notify parent
5. If pump was removed, send with EMS to hospital.

ADDITIONAL TIMES TO CONTACT PARENT

D Soreness or redness at infusion site
D Detachment of dressing/infusion set out of place
D Leakage of insulin
D Insulin injection given
D Other _____

Effective Date(s) of Pump plan:_____

Parent's Signature: _____ _____ Date _____

School Nurse's Signature: ____ _____ Date _____

Diabetes Care Provider Signature:_____ _____ Date _____

Revised February 3, 2003/Florida Governor's Diabetes Council

ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

Authorization to Conduct Blood Glucose Testing in Location other than the Clinic

Dear Parent/Guardian:

In order for your child to conduct his/her own blood glucose testing in a location outside of the clinic, your child must hand in this form with parts A and B fully filled out. Part C will be completed in the clinic with your child. Your child must be able to answer the questions in Part C or permission will not be granted. This is for the safety of your child and others. This form must be filled out IN ADDITION to the parent and licensed healthcare provider's consent and release for procedures identified in the diabetic care plan.

A. To be completed by the Florida licensed healthcare provider:

_____ has been instructed in the blood glucose testing procedure, the

assessment of testing results and the procedures to be followed after the results of the testing have been evaluated. He/she has been instructed to go to the clinic if the result of the blood glucose test is below _____ or above _____.

In my professional opinion, this student is responsible and should be allowed to test his/her blood glucose in a location other than the clinic, evaluate the results and react appropriately as indicated above.

Licensed Provider Signature Phone Date

B. To be completed by the parent/legal guardian:

I request that my child _____ be permitted to conduct blood glucose testing in the following locations, _____
_____My child has been instructed in, understands the purpose, appropriate method and frequency of blood glucose testing and is able to read, assess and react appropriately to the results. My child understands that he/she is responsible and accountable for carrying and using his/her glucometer. It is also understood that if there is any irresponsible behavior or safety risk, this *privilege* will be rescinded. I will support my child in following the agreement in Part C.

Parent/Guardian Signature Phone Date

C. To be completed by school nurse:

Student is consistently able to:	**Yes**	**No**
Perform blood glucose test correctly	_____	_____
Read test results	_____	_____
Determine correct action	_____	_____
Identify when testing is needed	_____	_____
Describe when to go to clinic	_____	_____
Student demonstrates safe disposal of lancet.	_____	_____
Student demonstrates correct disposal of test strip	_____	_____
Student understands his/her responsibility and agrees not to perform test on others	_____	_____

School Nurse Signature Phone Date

Revised September 2013

Date:_____

ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

Medical Questionnaire for Parents
School Year _____

Student's Name: _____ Date of Birth _____

Dear Parent:

School records indicate that your child has the following medical condition:
_____

Please provide the following information:

How long has your child had this illness? _____

When was your child last seen for this condition? _____

Does your child currently take medication for this condition at home or school? If yes, please explain:
_____
_____

Important: Medical information and medication authorization forms must be updated ANNUALLY. Therefore, if medical condition requires student to carry medication at school or if medication will be kept in clinic, you may download appropriate documentation from our website or contact the clinic to have forms mailed to you. Please refer to medication policy on school website. Thank you.

Are there any physical activities your child should not participate in? ☐ Yes ☐ No
If yes, explain: _____
_____

Important: If your child should not participate in physical education classes, a Physician's note is required.

Please add any additional information needed to safely care for your child:_____
_____

_____ _____ _____
Parent/Guardian Signature Print Name of Parent/Guardian Date

IF YOUR CHILD IS NO LONGER BEING TREATED FOR THIS CONDITION AND YOU WOULD LIKE IT REMOVED FROM THE SCHOOL RECORDS, PLEASE SIGN BELOW AND RETURN TO THE SCHOOL NURSE.

_____ _____ _____
Parent/Guardian Signature Printed Name of Parent/Guardian Date

***Revised September 2013**

ST. JOHNS COUNTY SCHOOL DISTRICT

AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

Student's Name: _____ Date of Birth:_____

School: _____ Grade: _____ Teacher/Homeroom: _____

NURSING SERVICES AND MEDICATION/TREATMENT ORDER

ALL INFORMATION MUST MATCH THE PRESCRIPTION LABEL! All medication must be properly labeled and in original containers. Complete one form for each medication/treatment to be administered.
A new form must be completed if the dosage of a medication changes at any time.

Nursing services are recommended for the care of this student during the school day.

It is necessary for the following medication/treatment to be given in school and during school sponsored activities. I am aware that non-medical personnel may administer this medication/treatment
Name of medication/treatment:_____Amount (Dosage):_____

Time to be given: _____Date to start: _____Date to end:_____

Health condition requiring medication: _____

Possible side effects: _____

Special instructions (i.e., may carry epi-pen/Glucagon on person)**: _____**

_____

Physician ordering medication: _____
(Print)

Physician's address: _____

Physician's phone: _____FAX: _____

Physician's signature: (required for all medications)_____

THIS SECTION FOR PARENT/GUARDIAN TO COMPLETE:

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them.

I authorize the physician to release information about this condition to school personnel.

_____	_____	_____
Parent/Guardian Signature	***Work/Home/Cell Phone***	***Date***

ASTHMATIC OR ALLERGIC STUDENTS: POSSESSION OF INHALERS OR EPIPENS — Florida Statute 1002.20
*Florida law states an asthmatic student or allergic student may carry a prescribed metered dose inhaler or epipen on his/her person while in school with approval from his/her parents **and** physician.*

The above named child may carry and self-administer his/her metered dose inhaler or epipen.
Parent/Guardian Signature:_____ Date:_____
Physician's Signature: (required) _____ Date:_____