LEON COUNTY SCHOOLS
DIABETES MEDICAL MANAGEMENT PLAN & NURSING CARE PLAN
(School Year _____-_____)

Student's Name: _____ Date of Birth: _____

Diabetes ☐Type 1 ☐Type 2 Date of Diagnosis: _____ Independent Management of Diabetes ☐ Yes ☐ No
(applies to High School students only)

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 Number: Home _____Work/Cell/Pager_____

MEAL PLAN TYPE: ☐ Carb insulin/Ratio ☐ Consistent Carbohydrate ☐ Other: _____

MEALS/SNACKS:

Student can determine correct portions and number of carbohydrate servings and/or carbohydrate grams ☐ Yes ☐ No
With Supervision ☐ Yes ☐ No

	Time/Location	Carb Content		Time/Location	Carb Content
☐ Breakfast			☐ Mid-afternoon		
☐ Midmorning			☐ Before PE/Activity		
☐ Lunch			☐ After PE/Activity		

BLOOD GLUCOSE MONITORING AT SCHOOL: ☐ Yes ☐ No

If yes, can student perform own blood glucose checks? ☐Yes ☐ No; Can student interpret results? ☐Yes ☐ No

Student needs supervision? ☐ Yes ☐ No

Time to be performed:
- ☐ Before breakfast
- ☐ Midmorning: before snack
- ☐ Before lunch
- ☐ Mid-afternoon
- ☐ Before Dismissal
- ☐ Before PE/Activity Time **(Give snack if BG less than _____)**
- ☐ After PE/Activity Time
- ☒ As needed for signs/symptoms of low/high blood glucose

Blood Glucose test to be performed in school clinic unless otherwise noted: _____

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No

Brand/Model: _____ Alarms set for: ☐ (Low) and ☐ (High)

****IF ALARM GOES OFF, CHILD IS TO REPORT TO CLINIC FOR BLOOD GLUCOSE CHECK****

Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

P.E., 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 gel, tube of cake icing, glucose tabs, gummies, etc. should be available at all times.

*****Child should not exercise if blood glucose level is below _____mg/dl OR if ketones are positive.*****

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

- ☐ Blood glucose meter, strips, lancets, lancing device
- ☐ Insulin pen/pen needles/cartridges
- ☐ Ketone testing strips
- ☐ Glucagon Emergency Kit (if prescribed)
- ☐ Glucose Gel &/or cake icing tube
- ☐ Other fast-acting carbohydrates (juice, glucose tabs, candies)
- ☐ Other carbohydrate-containing snacks (i.e. cheese crackers, candy)

For School Personnel Completion:

The following personnel are trained to provide care: _____

_____

Insulin Administration

INSULIN ADMINISTRATION DURING SCHOOL: ☐ Yes ☐ No **If yes, type of insulin**: _____
☐ School personnel not responsible for the administration of insulin

Student can: Determine correct dose? ☐Yes ☐No Draw up correct dose? ☐Yes ☐No
Give own injection? ☐Yes ☐No Needs supervision? ☐Yes ☐No

Insulin Delivery: ☐ Pen ☐ Pump ☐ Inhaled

Time to be given: ☐ Breakfast (☐Before ☐After); ☐ Lunch (☐Before ☐After); ☐ With Snack ☐AM ☐PM ☐ Other _____

***If "Before" meal is selected and child's blood glucose is ≤ 100mg/dL or unsure of child finishing all of meal, may give AFTER meal.**

☐ When blood sugar is over_____ **and** it has been _____hours since last insulin

Insulin Dosing: ☐ Insulin correction formula ☐ Carbohydrate ratio ☐ Sliding scale ☐ Standard daily insulin

CORRECTION FACTOR: 1 unit of insulin for every _____ points that blood glucose is above or below target of _____
☐ Add carbohydrate dose to correction dose.

CARBOHYDRATE RATIO:

☐ Breakfast: 1 unit of insulin per _____ grams of carbohydrates consumed
☐ Lunch: 1 unit of insulin per _____ grams of carbohydrates consumed
☐ AM Snack: 1 unit of insulin per _____ grams of carbohydrates consumed
☐ PM Snack: 1 unit of insulin per _____ grams of carbohydrates consumed

Note: If pre-meal BG is less than target, the amount calculated for total insulin will be less than the amount calculated for food (carb) intake.

SLIDING SCALE:

Blood sugar: _____- _____ Insulin Dose: ___
Blood sugar: _____- _____ Insulin Dose: ___
Blood sugar: _____- _____ Insulin Dose: ___
Blood sugar: _____- _____ Insulin Dose: ___
Blood sugar: _____- _____ Insulin Dose: ___

☐ **STANDARD DAILY INSULIN DOSE at school (i.e. student is on predetermined number of units at prescribed time[s]):**

Type of insulin:	**Dose:**	**Time to be given**:
_____	_____	_____
_____	_____	_____
_____	_____	_____

MANAGEMENT OF HYPERGLYCEMIA (HIGH) BLOOD GLUCOSE (over_____mg/dl)

Typical Signs/Symptoms of Hyperglycemia:

- Increased thirst, urination, appetite
- Tiredness/sleepiness
- Blurred vision
- Warm, dry, or flushed skin
- Other:
  _____

Emergency Hyperglycemia Signs/Symptoms:

- Nausea and/or vomiting
- Rapid, shallow breathing
- Fruity breath
- Severe abdominal pain
- Increased sleepiness/lethargy
- Depressed level of consciousness

Provide the following treatment:

- Give extra water and/or sugar-free fluids as tolerated
- Give insulin per DMMP
- Frequent bathroom privileges
- Check urine ketones if blood glucose over 300 mg/dl (2) times, and it has been (2) hours or more since last insulin or food.
- CALL parents if ketones are more than trace.

***If ketones are trace or lower it is not necessary for student to go home or to be kept in the clinic.**

When more than trace ketones are present:

- Stay with student and document changes in status.
- Call parent. If unable to reach parent, call diabetes care provider.
- **Delay exercise.**
- Student should be sent home.

MANAGEMENT OF HYPOGLYCEMIA (LOW) BLOOD GLUCOSE (below _____mg/dl)

Hypoglycemia Symptoms	
Mild to Moderate	Severe
• Shaky or Jittery • Clammy/Sweaty • Hungry • Pale • Headache • Blurry vision • Weak/Tired/Lethargic • Inattention/Confused/Disoriented • Dizziness/Staggering • Argumentative/Combative • Change in personality or behavior	• Slurred speech • Inability to eat or drink • Unconscious • Unresponsive • Seizure activity or convulsions (jerking movements)

- Usual symptoms for this student _____

Treatment for Mild to Moderate Hypoglycemia	Treatment for Severe Hypoglycemia
• Test Blood Glucose (BG) • Give 15 grams fast-acting carbohydrate such as: - 4oz. Fruit juice or non-diet soda - Concentrated glucose gel or tube frosting - 3-4 glucose tablets - 8oz. Milk - Other: _____ • Retest BG 15 minutes after treatment • Repeat treatment until blood glucose over _____mg/dl • Follow treatment with snack of _____ if it will be more than 1 hour until next meal/snack or if going to activity • Other: _____ _____ _____	**IMPORTANT!!!!** Administer glucose gel if student is awake but unable to drink or eat. **<u>If student is unconscious or having a seizure</u>, presume the student has low blood glucose and:** • **Trained personnel administer Glucagon ½ mg or 1mg (circle desired dose)** • **While treating, have another person call 911.** • **Position student on his or her side, and maintain this position until recovered from episode.** • **Contact student's parent/guardian.** • **Stay with student until Emergency Medical Services arrive.**

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 **(Required)**:_____Date: _____

Physician's Signature (**Required**): _____Date: _____

School Nurse's Signature (**Required**): _____Date: _____

Diabetes Medical Management Plan Adapted from Florida Governor's Diabetes Advisory Council for Leon County Schools- Revised May 11, 2015

ADDENDUM - FOR STUDENTS WITH INSULIN PUMP
LEON COUNTY SCHOOLS
DIABETES MEDICAL MANAGEMENT & NURSING PLAN
(School Year _____-_____)

Brand/Model_____ Pump Resource Person: _____ Phone # _____

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

STUDENT PUMP SKILLS			**ADDITIONAL COMMENTS:**
1. Independently count carbohydrates.	☐Yes	☐ No	
2. Calculate and administer carbohydrate bolus.	☐ Yes	☐ No	
3. Calculate and administer correction bolus.	☐ Yes	☐ No	
If pump alarms or insertion site becomes disconnected from the skin notify parent.			
Student can:			
1. Disconnect pump if needed.	☐ Yes	☐ No	
2. Change site.	☐ Yes	☐ No	
3. Give injection with pen, if needed and if pen available.	☐ Yes	☐No	

FOR INSULIN ADMINISTRATION: ***Follow instructions in basic diabetes medical management plan, but in addition:***

If blood glucose is tested _____ hour(s) after last bolus and it is above 300, follow these instructions:

1. Check for ketones.
2. Call parent and inform them of blood sugar and ketone status. ***(Call even if ketones are negative.)***
3. Administer correction bolus per instruction in page 2. If suspected pump site failure give insulin via pen if available.

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

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. Notify parent
4. If pump has been removed, send with EMS to hospital, or give to parent.

Effective Date(s) of Pump Plan: _____

Parent's Signature (Required):_____**Date:** _____

Diabetes Care Provider Signature (Required): _____**Date:** _____

School Nurse's Signature (Required): _____**Date:** _____

Diabetes Medical Management Plan Adapted from Florida Governor's Diabetes Advisory Council for Leon County Schools- Revised May 11, 2015

Florida Department of Health in Leon County

CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year_____

Student's Name: _____
DOB: _____
School: _____

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health inLeon County, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

(Please check *and* initial all that apply)

___ [**X**] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children's Medical Services
(Name of case manager: _____)
___ [**X**] Florida Department of Health in Leon County (Health Department)
___ [ ] Tallahassee Pediatric Foundation

___ [ ] Primary Physician_____
(Please fill in Physician name)
___ [ ] Specialist Physician_____
(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

_____ _____
Signature Date

LEON COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION OR TREATMENT
(Use one form for each medication. This permission form is valid for the current school year only.)

I hereby certify that it is necessary for my child, _____(first/last name)/_____ (date of birth), to be given the medication or treatment listed below during the school day, including when s/he is away from school property on official school business. I hereby authorize the School Board of Leon County, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his/her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration.

This form must be signed for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. **Only FDA-approved prescribed and over-the-counter medicines will be accepted.**

Name of medication: _____

Reason for medication (diagnosis): _____

Dosage to be given: _____Route (mouth, injection, etc.): _____

Time(s) of administration: _____Allergies: _____

Beginning date:_____Ending Date: _____ Amount of liquid or count of pills:_____

Emergency telephone numbers:

Parent/Guardian:_____H: _____C: _____

Parent/Guardian:_____H:_____C: _____

Doctor's Name:_____Doctor's Phone Number:_____

Prescription and over-the-counter medications/treatments shall come in original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall **only** be administered up to **five calendar days** without a signed a licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy **(see back of form).**

Parents are responsible for safe delivery of medication to the school (students may not transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

I hereby consent for the Leon County School District to disclose protected health information, as needed, to provide health services to my child. I understand this health information may be shared with the health care provider listed above, and I hereby authorize the exchange of this information. I also give permission for the information on this form to be utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby release, indemnify, and hold harmless LCSB, DOHLC and any of their officers, employees, contractors and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, DOHLC and their officers, employees, contractors and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

Date_____ Parent/Guardian Signature_____

AUTHORIZATION FOR MEDICATION OR TREATMENT

(Use one form for each medication. This permission form is valid for the current school year only.)

I hereby certify that it is necessary for my child, _____(first/last name)/_____ (date of birth), to be given the medication or treatment listed below during the school day, including when s/he is away from school property on official school business. I hereby authorize the School Board of Leon County, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his/her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration.

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Reason for medication (diagnosis): _____

Dosage to be given: _____Route (mouth, injection, etc.): _____

Time(s) of administration: _____Allergies: _____

Beginning date:_____Ending Date: _____ Amount of liquid or count of pills:_____

Emergency telephone numbers:

Parent/Guardian:_____H: _____C: _____

Parent/Guardian:_____H:_____C: _____

Doctor's Name:_____Doctor's Phone Number:_____

Prescription and over-the-counter medications/treatments shall come in original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall **only** be administered up to **five calendar days** without a signed a licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy **(see back of form).**

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Date_____ Parent/Guardian Signature_____

ACCEPTING MEDICATION FROM PARENTS –FAQ's

- Prescribed medications required to be given during school hours will be accepted.
- Over-the-Counter (OTC) medications will be accepted and administered for temporary medical conditions for a period no longer than 5 calendar days, and cannot be renewed beyond 5 days without a healthcare provider's written authorization.
- All medications must be transported to and from school by a parent, legal guardian, or designated adult.
- Before assisting any student with medication, a Medication Permission Form must be completed and signed by a parent or legal guardian.
- A separate Medication Permission Form must be completed for each medication, and is valid for the current school year in which it is completed (prescription medications only).
- All medications must be in the original container or packaging, and must contain labeled dosing instructions.
- Medication and doses of medication must be age-appropriate. Some non-prescription medications are not recommended for children. Check the box/bottle for this information.
- Before leaving medications at school, all medications must be counted, verified and documented by the parent / guardian and staff member on the Medication Log.
- Medications containing aspirin (Excedrin, Goody Powder, etc.) will not be accepted without a physician's written order, due to the association with Reye Syndrome.
- Only FDA-approved medications will be accepted. No vitamins, nutritional supplements, etc.
- Parents / Guardians may not change the dose or time of administration of any prescription medication. A physician's written order or new prescription bottle reflecting the change is required.
- Completed Medication Permission Forms must match the prescription or OTC dosing instructions.
- Students who carry medications allowed by Florida Statutes must have a completed Medication Permission Form and a written order from the physician to carry the medication on file in the school clinic.