LEON COUNTY SCHOOLS
DIABETES MEDICAL MANAGEMENT PLAN & NURSING CARE PLAN
(School Year _____-_____) Plan Effective Date(s):_____

Student's Name: _____ Date of Birth: _____

Date of Diabetes Diagnosis: _____ ☐Type 1 ☐Type 2

School Name: _____ School phone number: _____ School Nurse: _____

Grade _____ Homeroom _____ Independent Management of Diabetes ☐ Yes ☐ No

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: Meal Range: _____grams **to** _____grams

Student's self care nutrition skills: Snack Range: _____grams **to** _____grams

☐ Independently counts carbohydrates ☐ May count carbohydrates with supervision

☐ Requires school nurse/UAP diabetes personnel to count carbohydrates

Meal Plan (meals/snacks child to have):

"X" To Select	Meal	Time
	Breakfast	
	Mid-morning snack	

"X" To Select	Meal	Time
	Lunch	
	Mid-afternoon snack	

Instructions for when food is provided to the class (e.g., as part of class party or other event): _____

_____

BLOOD GLUCOSE MONITORING AT SCHOOL: ☐ Yes ☐ No ☐ School personnel not responsible for testing/monitoring, **but supplies are to be available**

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

Student's self care blood glucose checking skills:

☐ Independently checks own blood glucose ☐ May check blood glucose with supervision

☐ Requires school nurse/UAP diabetes personnel to check blood glucose

☐ Uses a CGM (continuous glucose monitor) &/or smart-phone to track blood glucose values

Time to be performed:

- ☐ Before breakfast
- ☐ Midmorning: before snack
- ☐ Before Lunch
- ☐ Mid-afternoon
- ✖ As needed for signs/symptoms of low/high blood glucose
- ☐ After PE/Activity Time
- ☐ 2-hours after a correction bolus
- ☐ Before Dismissal
- ☐ Before PE/Activity Time **(give snack if ≤ _____mg/dL to bring blood glucose to ≥ 100mg/dL)**

ADDITIONAL INFORMATION FOR STUDENT WITH CGM (CONTINUOUS GLUCOSE MONITOR):

The student should be escorted to the nurse/aid if the CGM alarm goes off: ☐ Yes ☐ No

- Confirm CGM results with a blood glucose meter check before taking action (hyperglycemia AND hypoglycemia)
- Insulin injections should be given at least three inches away from the CGM insertion site
- Do not disconnect from the CGM for sports/activities
- If the adhesive is peeling, reinforce with approved medical tape
- If the CGM becomes dislodged, return everything to the parent/guardian. DO NOT throw any part away

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
- ✓ Glucose Gel &/or Cake Gel Tube
- ✓ Other fast-acting carbohydrates (juice, glucose tabs)
- ✓ Other carbohydrate & protein snack: (i.e. peanut butter/cheese crackers, granola bars)

INSULIN ADMINISTRATION

INSULIN ADMINISTRATION DURING SCHOOL: ☐ Yes ☐ No **If yes, type of insulin**: _____

☐ School personnel not responsible for the administration of insulin

Student's self-care insulin administration skills:

☐ Independently calculates and gives own injections ☐ May calculate/give own injections with supervision

☐ Requires school nurse or UAP to calculate dose and student can give own injection with supervision

☐ Requires school nurse or UAP to calculate dose and give injection

Insulin Delivery: ☐ Pen ☐ Pump

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

****If "before" meal is selected and blood glucose is ≤ 100mg/dL or unsure if child will finish all of the meal, may give after meal****

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

CORRECTION FACTOR: 1unit of insulin for every ____ points that blood glucose is above or below target of _____mg/dL

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.

☐ Add correction dose to carbohydrate dose at meals

Correction Example

$$\frac{Current\ BG - Target\ BG}{Correction\ Factor} = \_\_\_Units\ of\ Insulin$$

CARBOHYDRATE (carbs) RATIO:

☐ Breakfast: 1 unit of insulin per _____ grams of carbs consumed

☐ AM Snack: 1 unit of insulin per _____ grams of carbs consumed

☐ Lunch: 1 unit of insulin per _____ grams of carbs consumed

☐ PM Snack: 1 unit of insulin per _____ grams of carbs consumed

Carbohydrate Example

$$\frac{Grams\ of\ Carb\ to\ be\ eaten}{Insulin\ to\ Carb\ Ratio} = \_\_\_Units\ of\ Insulin$$

SLIDING SCALE:

Blood sugar: _____- _____ Insulin Dose: ____

Blood sugar: _____- _____ Insulin Dose: ____

Blood sugar: _____- _____ Insulin Dose: ____

Blood sugar: _____- _____ Insulin Dose: ____

Blood sugar: _____- _____ Insulin Dose: ____

☐ **FIXED 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**:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PARENTS/GUARDIANS AUTHORIZATION TO ADJUST INSULIN DOSE

****Must be signed/initialed by healthcare provider AND Parents wishing to make changes are to contact the School's Registered Nurse****

MD initial

_____ ☐ Yes ☐ No Parents/guardians authorization should be obtained before administering a correction dose

_____ ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease correction factor within the following range: **+/-** _____ points that the blood glucose is above/below target blood glucose

_____ ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease carb ratio within the following range: 1 unit per prescribed grams of carb. +/- _____ grams of carb.

_____ ☐ Yes ☐ No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: **+/-** _____ units of insulin

PHYSICAL ACTIVITY, SPORTS, and EMERGENT SITUATIONS (i.e. lockdown, fire, etc)

Quick access to water, fast-acting carbohydrate (glucose tabs, gummies, gel), and monitoring equipment is recommended to be available at all times.

MANAGEMENT OF HYPERGLYCEMIA (HIGH) BLOOD GLUCOSE (over 350 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
- Use Insulin correction formula when blood sugar is over **350 and it has been 2 hours since last insulin, *CALL SCHOOL RN FIRST***
- Frequent bathroom privileges
- Check urine ketones if blood glucose over **350** mg/dl
- Return to clinic in 1 hour to recheck blood glucose if ketones trace or lower.
- 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 ketones of small or greater are present:

- Stay with student and document changes in status.
- Call parent. If unable to reach parent, call School RN for appropriate instruction and/or contact of diabetes care provider.
- Student should be sent home.

MANAGEMENT OF HYPOGLYCEMIA (LOW) BLOOD GLUCOSE (below 70 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: - 3-4 glucose tablets ***(preferred)*** - 4oz. Fruit juice or **non**-diet soda - Concentrated glucose gel or tube gel (for child with trouble swallowing) - 8oz. Milk - Other: _____ • Retest BG 15 minutes after treatment • Repeat treatment until blood glucose over 90 mg/dl • **Follow treatment with snack of 15 gr with protein** (i.e. cheese OR peanut butter crackers) ***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** **< 9 years old ½ mg** **≥ 9 years old 1mg** • **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.** • **Notify EMS if student on insulin pump**

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: _____

For School Personnel Completion:

The following personnel are trained to provide care: _____

_____

THIS

AREA

LEFT

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

Effective Date(s) of Pump Plan: _____

Brand/Model of pump: _____

☐ For blood glucose greater than 300mg/dL that has not decreased within 2 hours **after correction**, consider pump failure or infusion site failure. Notify parent(s)/guardian(s) and refer to the ***Student's Self-Care Pump Skills*** below. ***Parent action is required if student is not independent. If unable to reach parent/guardian, contact school RN.***

Physical Activity

May disconnect from pump for sports activities:	☐ YES , for up to _____ minutes	☐ NO
Set a temporary basal rate:	☐ YES , ____% temporary basal for _____ minutes	☐ NO
Suspend pump use:	☐ YES , for up to _____ minutes	☐ NO

Student's Self-Care Pump Skills	Independent	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alerts and alarms	☐ Yes	☐ No
Give injection with pen/syringe if needed **and** pen/syringe available	☐ Yes	☐ No

Supplies to be furnished by parent(s)/guardian(s) based upon the *Student's Self-Care Pump Skills*:

☐ Infusion set/reservoir ☐ Batteries ☐ Rapid acting insulin pen or syringe to administer injection

SIGNATURES

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

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

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

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_____

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.