Homer Rice
Administrator

Jackie Pons
Superintendent

Dear Parent/Guardian,

Enclosed are the Diabetes Medical Management Plan and related medical forms for the 2012-2013 school year to be **completed by you and your child's healthcare provider**. These documents provide a guide for your child's care during the school day. The Registered Nurse assigned to your child's school will provide training to designated school personnel based on this Medical Management Plan.

The following documents need to be completed and returned to the school clinic as soon as possible to ensure the best care and safety of your child:

- Diabetes Medical Management Plan (signed by parent/guardian **and** physician)
- Consent for Sharing of Medical Information (check off each applicable agency **and** add other provider if not listed)
- Authorization for Carrying Medication (signed by physician for students who carry their insulin **and/or** diabetes management supplies)
- Medication Permission Form (completed for each medication, even if your child carries all medication and supplies)

❖ **Please note that you must supply all diabetes supplies to your child's school including fast-acting carbohydrates (e.g. juices) and snacks (e.g. peanut butter crackers).**

Remember to keep copies of these documents for your records!

If you have any questions please contact Leon County Health Department, School Health Division, at 606-8150.

Sincerely,

Nancy Cooper, RN, BSN, NCSN

Nancy Cooper, RN, BSN, NCSN
School Health Coordinator
Leon County Health Department

**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
- ☐ Nausea; vomiting
- ☐ Abdominal pain
- ☐ Rapid, shallow breathing
- ☐ Fruity breath
- ☐ Other _____

**Provide the following treatment:**

- Sugar-free fluids as tolerated
- Check urine ketones if blood glucose over _____mg/dl
- Notify parent if urine ketones positive.
- Frequent bathroom privileges

***When more than trace ketones present:***

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

***Insulin administration for correction of high BG may be provided by trained school personnel via direct written/faxed order from diabetes care provider, or insulin may be administered by parent. Parent also may provide insulin instructions directly to students who are capable of self-injection or who can independently manage insulin pump.***

**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_____

**Provide the following treatment:**

***If student is awake and able to swallow,***
*give **15 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 15 minutes after treatment
Repeat treatment until blood glucose over _____mg/dl
Follow treatment with snack of _____
if more than 1 hour until next meal/snack or if going to activity
☐ Other _____
_____
_____

**IMPORTANT!!**

***Administer glucose gel if student is awake but has documented low blood glucose and is vomiting or unable to swallow. Notify parent. (If Glucagon is used, must call 911 – see below.)***

***<u>If student is unconscious or having a seizure</u>, presume the student has low blood glucose and:***

**Call 911 immediately. Notify parents after calling 911 and administering Glucagon or gel.**

☐ **Glucagon** ½ mg or 1 mg **(circle desired dose)** should be given by trained personnel.

***Student should be turned on his/her side and maintained in this "recovery" position until 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 **(Required)**:_____ Date: _____

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

School Nurse's Signature: _____ Date: _____

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

Revised May 4, 2006

# [illegible]
# DIABETES MEDICAL MANAGEMENT PLAN
School Year: [illegible]

Student's Name: _____ Date of Birth: _____ Diabetes ☐Type 1 ☐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 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 serving ☐ Yes ☐ No

Calculate carbohydrate grams accurately ☐ Yes ☐ No

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

Notify parent if outside food for party or food sampling provided to class. ☐ Yes ☐ No (Blood glucose correction will be done at next scheduled meal.)

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

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

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

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

**INSULIN ADMINISTRATION DURING SCHOOL:** ☐ Yes ☐ No ☐ School personnel not responsible for the administration of insulin

**If yes, type of insulin:** _____

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

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

**Insulin Delivery:** ☐ Pen ☐ Pump (If pump worn, use "Supplemental Information Sheet for Student Wearing an Insulin Pump") ☐ Inhaled

**Time to be given:** ☐ Breakfast: (☐ Before ☐ After); ☐ Lunch: (☐ Before ☐ After); ☐ Other (Specify time; ***not*** "as needed"): _____

**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:** 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: |
|---|---|---|
| | | |
| | | |

**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 _____ 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/RESTOCKED BY PARENT/GUARDIAN: (Agreed-upon locations noted on emergency card/action plan)**

- Blood glucose meter/strips/lancets/lancing device
- Fast-acting carbohydrates (juice, glucose tab, icing gel)
- Other carbohydrate-containing snacks (crackers, candy)
- Carbohydrate-free snack (e.g. cheese, beef jerky)
- ☐ Insulin pen/pen needles/cartridges
- ☐ Ketone testing strips
- ☐ Glucagon Emergency Kit (if prescribed)

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

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

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

Blood Glucose Target:_____ Pump Insulin: ☐ Humalog ☐ Novolog ☐ Regular

Insulin: Carbohydrate Ratios: 1 unit for every _____ grams of carbohydrates consumed Pre-programmed in pump: ☐ Yes ☐ No

(Student to receive carbohydrate bolus after lunch)

Insulin Correction Formula for Blood Glucose Over Target: 1 unit of insulin for every _____ points that blood glucose is above or below target of _____ Pre-programmed in pump: ☐ Yes ☐ No

| 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 | |

**MANAGEMENT OF CONTINUED HIGH BLOOD GLUCOSE FOLLOWING A BOLUS:** ***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 ketones.
2. Call parent and inform them of blood sugar and ketone status. (Call even if ketones are negative.)
3. Administer correction bolus, following Insulin Correction formula stated below:
   Blood glucose - _____+ _____=_____ units insulin
4. Check blood sugar in 2 hours, if student is still in school at that time.
5. If blood sugar is still above 300 after 2 hours, check ketones and 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 or disconnect 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
   - ☐ Detach set from skin
4. Notify parent
5. If pump was removed, send with EMS to hospital, or give to parent.

**ADDITIONAL TIMES TO CONTACT PARENT:**

- ☐ Soreness or redness at infusion site
- ☐ Leakage of insulin
- ☐ Other:_____

Effective Date(s) of Pump plan: _____

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

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

School Nurse's Signature:_____ Date:_____

Revised May 4, 2006/Adapted from Florida Governor's Diabetes Council for Leon County Schools

**LEON COUNTY SCHOOLS**
**MEDICATION PERMISSION FORM**
**(One form for each medication)**

I hereby certify that it is necessary for _____ Date of Birth: _____
(Full Name of Student - List all names used by student)
Teacher/Homeroom: _____ Grade Level: _____
to be given the medication listed below during the school day, including when he/she is away from school property on official school business. Without this medication, he/she will not be able to attend school.

Signed form is necessary for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc.) Only FDA-approved 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: _____ W: _____ C: _____

Parent/Guardian: _____ H: _____ W: _____ C: _____

Doctor's Name: _____ Phone: _____

Prescription and non-prescription medication shall come in the original container and shall be labeled. Changes in the medication times or dosage can only be made by written prescription from the physician, which may be faxed to school health personnel. This permission form is valid for the current school year only.

Parents are requested to pick up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded.

I hereby consent to protected health information being used and disclosed to carry out treatment, payment, or health care operations of my child. I understand that the Leon County School District may need to give and receive protected health information pertaining to the management of my child's medical condition with the health care provider listed above, and I hereby authorize the exchange of this information as needed to carry out the treatment, payment or health care operations of my child. I also give permission for the information on this form to be reviewed and 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 authorize the School Board of Leon County, Florida ("LCSB") and Leon County Health Department ("LCHD"), 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 or her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration. I hereby release, indemnify, and hold harmless LCSB and LCHD 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, LCHD 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)

# LEON COUNTY SCHOOLS
## AUTHORIZATION FOR CARRYING MEDICATION

Date: _____

To Whom it May Concern:

_____ is a student at _____.
(Name of Student) (Name of School)

It is medically necessary for him/her to carry the following medication(s)*:

Medication: _____
Reason for carrying: _____
_____

Medication: _____
Reason for carrying: _____
_____

Medication: _____
Reason for carrying: _____
_____

This authorization is valid for the current school year only (if for specific dates, please specify above). Additional information may be obtained from

_____
(Physician Name)

at _____ (Phone) or _____ (Fax)

Respectfully signed,

_____, M.D.
M.D. Signature or Office Stamp

*The student has demonstrated that he/she is responsible in the use and storage of the above medication(s).

_____ _____
LCHD School RN Date