



Bay District Schools Diabetes Medical Management Plan for School Year 2020-2021

Student Name	DOB:	Student ID:	Grade:
Parent/Guardian #1:	Cell#:	Home#:	Work#:
Parent/Guardian #2:	Cell#:	Home#:	Work#:
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 May Self-insert Pump Infusion Set	<input type="checkbox"/>	<input type="checkbox"/>
Student can carry diabetes supplies, determine insulin dose, and self-administer insulin via insulin pen <input type="checkbox"/> or insulin pump <input type="checkbox"/>	<input type="checkbox"/>	

Students who require no supervision will be allowed to carry diabetic supplies and self-administer insulin with written physician and parental authorization, per Florida Statute 1002.20(3)(j).

Testing Blood Glucose at School

Test Blood Glucose with Glucometer before administering insulin and as needed for signs and symptoms of high or low blood glucose levels. **May use Continuous Glucose Monitor (CGM) for dosing if BG between: _____ mg/dl.**

Additional Blood Glucose Testing at school: Before PE After PE Before Snack **OR** _____

LOW Blood Sugar (HYPO-glycemia) – Test Blood Sugar to Confirm

Student recognizes when he/she has signs of LOW blood Sugar Yes No

Student Signs and Symptoms may include: Hungry Weak/Shaky Headache Dizziness Stomach Ache
 Anxious Personality Changes Nausea/Vomiting Confusion Fatigue Drowsiness Blurred Vision
 Other _____

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

1. If student is awake and able to swallow: Give **15** grams of a fast-acting carbohydrate such as:
2. 4oz. fruit juice or non-diet soda, 3-4 glucose tablets, or tube frosting, snack provided by parent, or other _____
3. Repeat the above treatment until blood glucose is over _____ mg/dl. Student may then return to class.
4. Follow treatment with snack of _____ grams of carbohydrates if more than 1 hour until next meal/snack or if going to activity.
5. Notify parent when blood glucose is below _____ mg/dl.
6. Delay exercise if blood glucose is below _____ mg/dl.

If student is unconscious or having a seizure, call 911 immediately and notify parents. Position student on left side if possible. If wearing an insulin pump, place pump in suspend/stop mode or _____

Administer:

Glucose Gel: One tube administered inside cheek and massaged from outside while waiting for Glucagon to be mixed and administered.

Glucagon: Administer 0.5mg 1.0 mg Glucagon Injection IM SQ

Baqsimi (glucagon): Administer 3.0mg nasal powder

Student's Name: _____		DOB: _____	
HIGH Blood Sugar (HYPER-glycemia) – Test Blood Sugar to Confirm			
Student recognizes when he/she has signs of HIGH Blood Sugar <input type="checkbox"/> Yes <input type="checkbox"/> No			
Students Signs and Symptoms may include: Increase in <input type="checkbox"/> Hunger <input type="checkbox"/> Thirst <input type="checkbox"/> Urination <input type="checkbox"/> Headache <input type="checkbox"/> Stomach Ache <input type="checkbox"/> Warm, Dry, Flushed Skin <input type="checkbox"/> Fatigue <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Drowsiness <input type="checkbox"/> Confusion <input type="checkbox"/> Sweet, Fruity Breath <input type="checkbox"/> Other: _____			
Management of High Blood Glucose (over _____ mg/dl)			
<ol style="list-style-type: none"> 1. Refer to the Insulin Administration section below for designated times insulin may be given. 2. Give water or other sugar free liquids as tolerated, and allow frequent bathroom privileges. 3. Check ketones if blood glucose is over _____ mg/dl. 4. Student may return to class for blood glucose of _____ mg/dl. 5. Notify parent if ketones are positive and /or blood glucose over _____ mg/dl. 6. Delay exercise if blood glucose is above _____ mg/dl 7. Retest blood glucose in _____ hours if above _____ mg/dl. 8. If blood glucose over _____ mg/dl, and is not responding to interventions, contact parent for student pick up. 9. If unable to reach parent, monitor student, CALL 911 for BG greater than _____ mg/dl, or student develops labored breathing, becomes very weak, confused, unconscious, and/or begins seizing. 			
Other: _____			
Insulin Administration:			
Insulin correction for high blood glucose at school: <input type="checkbox"/> Before Breakfast <input type="checkbox"/> Before Lunch <input type="checkbox"/> Blood glucose _____ mg/dl and has been _____ hours since last insulin dose <input type="checkbox"/> Other: _____			
Type of Insulin at school: <input type="checkbox"/> Humalog <input type="checkbox"/> Novalog <input type="checkbox"/> Other _____			
Method of Insulin Delivery at school	<input type="checkbox"/> Insulin Pen	<input type="checkbox"/> Insulin Pump: Pump will calculate insulin dose. Note: If blood glucose is above _____ mg/dl, pump will prescribe insulin dosage. If pump fails, use pen/syringe to administer insulin per Insulin administration guidelines. Parents are responsible for supplying all additional supplies associated with this action.	
Target Blood Glucose: _____ mg/dl.			
Carbohydrate Insulin Dose	Give one unit of insulin per _____ grams of carbs		
Insulin for Carbs eaten at school, indicate times:	<input type="checkbox"/> Before Breakfast <input type="checkbox"/> Before Lunch <input type="checkbox"/> Before Snack <input type="checkbox"/> Other: _____		
Insulin Correction Factor	Give one unit of insulin for every _____ mg/dl that Blood Sugar is Above or Below Target Blood Sugar.		
<input type="checkbox"/> Call Parent for Blood Glucose Correction, and Insulin Determination			
High Blood Sugar Correction Dose – Use Insulin Sliding Scale			
Blood Sugar _____ to _____	Insulin- _____ units	Blood Sugar _____ to _____	Insulin- _____ units
Blood Sugar _____ to _____	Insulin- _____ units	Blood Sugar _____ to _____	Insulin- _____ units
<p>I hereby authorize the above-named Diabetes Healthcare Provider and Bay District Schools/PanCare of Florida, Inc. staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for giving necessary medication or treatment while at school. I understand Bay District Schools and PanCare protect and secure the privacy of student health and education 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 request that my child be assisted in taking the medication or treatment described above at school by authorized persons as permitted by me and my physician. I understand that all snacks and supplies are to be furnished/restocked by parent/guardian. I understand that all procedures will be implemented in accordance with Florida state law and regulations and may be performed by unlicensed designated school personnel (FL Statute 1006.062) under the training provided by the school nurse.</p>			
Parent/Guardian Signature _____		Date _____	
Physician/Practitioner Signature _____		Date _____	
<p>Per the directives of the parents, _____ will be allowed to independently perform blood glucose monitoring, carbohydrate counting, insulin dose determination and administration. The school staff will not have any responsibilities concerning these activities. I will complete and return the Individual Care Plan for my child with instructions regarding emergency care.</p>			
Parent/Guardian Signature _____		Date _____	
Reviewed by:	School Health Registered Nurse		Date _____

