CCPS
Collier County Public Schools

ISTWA SANTE ELÈV LA - DYABÈT

Non Elèv la: ________________________________ Nimewo li: ____________________

Dat Nesans: ___________ Lekòl: _______ Pwofesè/Klas: _____________________

Doktè li: _______________ Nimewo Doktè a: ______________ Monte Bis: Wi__Non__

Alèji: ____

Paran/Responsab: _______________________ Telefòn Lakay: _________ Lòt Telefòn: _____________

Paran/Responsab: _______________________ Telefòn Lakay: _________ Lòt Telefòn: _____________

Kontak Ijan: __________________________ Telefòn Lakay: ___________ Lòt Telefòn: _____________

Relasyon: ___________________________

Kontak Ijan: __________________________ Telefòn Lakay: ___________ Lòt Telefòn: _____________

Relasyon: ___________________________

Ane li dyagnostike avèk dyabèt la: _______________

Eske pitit ou a pran ensilin lakay la? ☐ Wi ☐Non Si wi, ki kalite: ________________ Lè (yo): __________

Eske yo egzije pou administre ensilin nan lekòl la? ☐ Wi ☐ Non

Si yo preskri li, èske ou genyen pou bay pitit ou a Glikagon? ☐ Wi ☐ Non

Moun ki ap pran swen sante timoun nan dwe konplete yon Plan Jesyon Medikal pou Dyabèt

JESYON PONP ENSILIN

Non ponp la: ________________________________ Nimewo Manifakti a: ____________________

Pitit mwen an kapab chanje aparèy enfizyon ensilin li a avèk prekosyon estanda yo. ☐ Wi ☐ Non

Si elèv la pa kapab chanje aparèy la pou kont li, yo pral avèti paran li

Pitit mwen an kapab bay tèt li piki ensilin la avèk yon sereng oswa pen si ponp la pa fonksyone byen. ☐ Wi ☐ Non

Paran dwe bay ekstra materyèl ki enkli, men ki pa limite a sa sèlman: aparèy enfizyon, rezèvwa, batri, ensilin, sereng, ak nenpòt lòt ekipman ki asosye avèk li.

Yo pral kontakte paran si nenpòt nan bagay sa yo rive nan lekòl la:

- Si kote pou plase ponp la yon jan redi oswa li yon jan wouj
- Genyen eleman ki detache
- Yo bezwen chanje kote pou mete ponp la
- Mezi korektif pou retounen glikoz sangen nan ranje sib pòte li yo
- Aparèy enfizyon an pa nan plas li.

*Tanpri konplete li e siyen paj dèyè a

ISTWA SANTE ELÈV LA - DYABÈT

FRIYANDIZ
Eske li egzijib pou pitit ou a pran yon ti kolasyon nan lekòl la? ☐ Wi ☐ Non Endike lè a _______________

Paran dwe pote friyandiz, kontwole li epi ranplase li si sa nesesè.

PLAN IJAN:

- Nan ka kote genyen yon danje nan lekòl la, medikaman ki nan klinik yo papral disponib pou pitit ou itilize. Nou ankouraje ou diskite yon plan avèk doktè pitit ou a epi avèk enfimyè lekòl la. Tanpri note nenpòt enstriksyon espesyal ki dwe enkli nan Plan Aksyon Ijan pitit ou a ki anba.
  ____
- Nan ka kote ta va genyen yon evakyasyon, yo pral transfere medikaman ijan nan syèj evakyasyon an, nenpòt lè sa posib.

Mwen konprann ke moun kap pran swen sante pitit mwen an dwe konplete yon **Plan Jesyon Medikal pou Dyabèt,** bay swen espesifik pou yo pran nan lekòl e endike ki pwosedi ke elèv kapab oswa pakapab pèfòme pou kont yo.

Mwen konprann ke Plan Aksyon Ijan pitit mwen an pral pataje avèk manm pèsonèl lekòl apwopriye ki bezwen konnen kondisyon sante a. Mwen konprann davantaj ke lekòl la pa responsab pou domaj oswa ekipman ki pèdi ke yo itilize pou bay tretman oswa pwosedi medikal ke yo preskri a.

Mwen bay pèmisyon pou kontakte moun kap bay pitit mwen an swen sante pou founi enfòmasyon konsènan kondisyon medikal pitit mwen an. Mwen te revize epi dakò avèk enfòmasyon ke yo bay nan fòm Istwa Sante a.

Paran/Responsab: ______________________________ ____________________
Siyati Dat

Revize pa: ______________________________ ____________________
Enfimyè Lekòl la Dat

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FOR SCHOOL NURSE USE ONLY

Notes: ____

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Rev 4/18

Student Name _____________________ # ______________

The District School Board of Collier County
Diabetes Medical Management Plan

This form provides professional and parental authorization for medical treatment to be provided. Both the prescribing health care provider and the parent/legal guardian are required to complete the respective sections of this document entirely before the services can be provided.

Student's Name ____________ Sex ______ Date of Birth ________ Student # ________

School ____________ Fax Number ________

Note: Please have your child's physician complete this portion of the form and return it or fax it to the school nurse.
It is the parent's/guardian's responsibility to notify the school if and when these orders change.

The following section is to be completed by the prescribing health care provider:

DIAGNOSIS: ☐ **DIABETES TYPE 1** ☐ **DIABETES TYPE 2** ☐ **OTHER** ___________

BLOOD GLUCOSE MONITORING

To be performed by student? ☐**Yes** ☐**No**

Location for testing: ☐ Clinic/Health Room
☐ Classroom ☐ Other_______________

Time, frequency of testing during school hours:
☐ Lunch ☐ PRN symptoms of hypoglycemia/hyperglycemia
☐ Before P.E. ☐ Before Dismissal
☐ Dexcom Instructions: ________________________________

INSULIN ADMINISTRATION

Student requires the ROUTINE administration of ____________ type of insulin.

Route: ☐Pen ☐Pump ☐Injection
☐ If pump failure, use sliding scale.

Frequency:
☐ Lunch
☐ PRN per physician verbal order
☐ Other ____________________

Target Range: _______________

Insulin/Carbohydrate Ratio: ______

Correction Factor: ___________

Please indicate which activities the student may perform without supervision:

Can student perform blood glucose monitoring?	☐ Yes	☐ No
Can student perform urine ketone testing when indicated?	☐ Yes	☐ No
Can student administer own insulin via prescribed route?	☐ Yes	☐ No
Can student determine correct amount of insulin?	☐ Yes	☐ No
Can student draw-up correct amount of insulin?	☐ Yes	☐ No
Student is authorized to self-carry glucometer/supplies	☐ Yes	☐ No
Student is authorized to self-carry and administer insulin	☐ Yes	☐ No
Student may self-carry fast-acting glucose snacks	☐ Yes	☐ No
Student may self-carry glucagon	☐ Yes	☐ No

PRE-MEAL SLIDING SCALE INSULIN

High BG Levels

For BG levels:	Sliding Scale Insulin
Between ____ – ____	# Units_______Type_______
Between ____ – ____	# Units_______Type_______
Between ____ – ____	# Units_______Type_______
Between ____ – ____	# Units_______Type_______
Between ____ – ____	# Units_______Type_______

High BG Levels:
≥ ________
☐ Check ketones
☐ Call physician & parent if mod.– large ketones
☐ Other ________________________________

ICD 10 Code _______

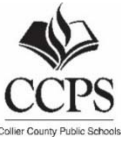
Low BG levels: If BG is below __________, take the following actions:

☐ Give 15 gm. of fast-acting glucose/gel/tabs. Recheck in 15 minutes. If <80, give additional 15 grams of fast-acting glucose and recheck in 15 minutes. If >80, and not lunchtime, give 15 grams of complex carbs (crackers, granola bar)
☐ If >80 at lunchtime, send to lunch

GLUCAGON ADMINISTRATION

☐ I have prescribed injectable Glucagon for this student	Dosage:	Frequency:

Please see other side-



The District School Board of Collier County
Diabetes Medical Management Plan

Student Name: ____ **Student ID#** __________________

The student named in this document is under my medical supervision. I have prescribed the care/treatment that is necessary to be given during school hours for the child's health or safety. I am also aware that prescribed care or treatments may be administered by trained diabetes personnel.

Physician's Name (Print): ____ Phone Number: __________

Physician's Signature: ______________________________ Date: _______ Fax Number: ____________

Physician's Address: ____

Parent/Legal Guardian Permission

The following section is to be completed by the parent/legal guardian:

I hereby grant permission to the Principal or his/her designee of ______________________________ school to assist in the administration of the care/treatment prescribed in this order for my child while in school, while participating in official school activities such as field trips, and during after-school programs operated by Collier County Public Schools. (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change. A new written Authorization for Diabetes Care/Treatment will be needed.** I understand that the law provides there shall be no liability for civil damages as a result of the administration of such care/treatment where the person administering such care/treatment acts as an ordinarily prudent person would under the same or similar circumstances. If my child is authorized to carry diabetic supplies or equipment, I indemnify the school district, county health department and any public-private partner, and the employees and volunteers of those organizations, from any and all liability with respect to my child's use of such supplies and equipment.

1. I hereby give permission for my child's doctor or other authorized health care practitioner to be contacted for information regarding my child's illness, health or medical condition that may require nursing care or treatment.
2. I hereby authorize the school nurse or trained diabetes personnel to perform nursing care or treatments that may be prescribed by my child's authorized health care provider for the school day or while my child is participating in school related activities, including administration of glucagon.
3. I understand and I agree that I am responsible for providing the equipment, supplies, snacks, and/or prescribed medications to the school that are required to perform these services.
4. I understand that all medications, materials and supplies not picked up at the end of the school year, or when medication or materials have an expired "discard after date" or a manufacturer's expiration date that has passed will be disposed of per current District protocol, following verbal and/or written notification to the parent/guardian.
5. This Authorization is effective as of the date it is received at the child's school and it supersedes all previous authorizations or orders. This Authorization shall remain in effect until changed by the physician.
6. This Authorization must be renewed annually.

My child has:	☐ No allergies, ☐ The following allergies:______________________________		
Parent/Guardian Name:		Relationship:	
Home Phone:		Cell Phone:	
Parent/Guardian Signature:		Date:	

Reviewed by: ____ Date: ________
School Nurse

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