The District School Board of Collier County
Diabetes Medical Management Plan

Student's Name: ______________________ Sex: M☐ F☐ Date of Birth: ________________

Student #: ________________ School Name: ____________________ Fax Number: ___________

Diagnoses: Diabetes Type 1__ Diabetes Type 2 __ Other __ ICD 10_______________

Blood Glucose Monitoring

☐Blood Glucose Meter ☐ Continuous Glucose Monitor

☐ Smart phone or other monitoring technology to track Blood Glucose levels

Can the student perform their own Blood Glucose?

	Yes or	No
Independently checks Blood Glucose	☐	☐
May check Blood Glucose with Supervision		☐
Requires Nurse or other clinic staff to check Blood Glucose for the student	☐	☐

Blood Glucose testing during school hours:

☐ before breakfast ☐ before lunch ☐ before PE/ activity time

☐ before dismissal

☐ Give 15 gm snack if Blood Glucose is ______mg/dl before dismissal.

☐ prn symptoms of hypoglycemia or hyperglycemia

Continuous Glucose Monitor (CGM) Instructions ______________________________________

☐ May be used for insulin calculation if glucose is between ___ mg/dl and ___ mg/dl.

Target range for Blood Glucose ____________ mg/dl to ___________mg/dl (optional**)**

Hyperglycemia/ High Blood Glucose Levels:

More than or equal to __________mg/dl

☐ Check urine for Ketones

☐ Notify Physician and Parents

☐ Encourage increased water intake.

☐ Other ____________________________________

Hypoglycemia/ Low Blood Glucose

- If blood glucose level is less than 80mg/dl, give a quick acting glucose (fruit juice, glucose tablets) product equal to 15gm.
- Recheck Blood Glucose in 15 minutes. If less than 80 mg/dl and **not lunchtime** give 15gms of a complex carb. (Crackers, granola bar)
- If more than 80mg/dl at lunchtime, send to lunch.

If the student is unable to eat or drink, unconscious or unresponsive or is having seizure activity or convulsions:

☐ Baqsimi 3mg intranasal prn, insert into one nostril and push plunger down completely.

☐ Glucagon: 0.5mg or 1 mg, IM prn ☐ Gvoke: 0. 5mg or 1mg, SC prn

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Insulin Therapy

The student: (Select one)

☐ Can **independently** calculate insulin to carb ratio and give own injections.

☐ May calculate insulin to carb ratio and give own injections **with supervision**.

☐ **Requires nurse/other clinic staff** dose and the student can give own injection with supervision

☐ **Requires nurse/other clinic staff up to calculate dose and give** the injections.

Insulin Administration

Insulin delivery device: ☐ **syringe** ☐ **pen** ☐ **pump** ☐ **If pump failure, use sliding scale. Insulin Type:**

____

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

Target Range: ______________ **Insulin-to-carbohydrate ratio: _____ Correction Factor: _______**

Insulin Pump settings: Basal rate ____

PRE-MEAL SLIDING SCALE

Blood sugar between ____ -____ Insulin dose _______ units

Blood sugar between ____ -____ Insulin dose _______ units

Blood sugar between ____ -____ Insulin dose _______ units

Blood sugar between ____ -____ Insulin dose _______ units

Blood sugar between ____ -____ Insulin dose _______ units

Physical Activity, Sports and Field Trips

A fast-acting carbohydrate/snack should be available at the site.

If Blood Glucose is _________mg/dl **before** PE/Activity give 15 gm snack

Student should not exercise if Blood glucose level is below ____mg/dl ***OR***

if blood glucose level is above ____mg/dl.

INSULIN PUMP: Set activity mode on pump ___ minutes before activity __N/A

Instructions for when food is provided to class: ____

Parent/Legal Guardian Permission

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 maybe 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.

Parent/Guardian Signature ____________________________ Date:________________ PH# _______________

Student Signature ___________________________________ Date: ________________

Physicians Signature _________________________________ Date: ________________ Fax#________________

School Nurse Signature ______________________________ Intial Date: ________ Mid-Year Review:______