# Bay District Schools
# Diabetes Medical Management Plan for School Year 2024-2025

| 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 | ☐ | ☐ |
| Calculates Carbohydrate Grams | ☐ | ☐ |
| Determines Insulin Dose for Carbohydrate Intake | ☐ | ☐ |
| Determines Correction Dose of Insulin for High Blood Glucose | ☐ | ☐ |
| Student May Self-Insert Pump Infusion Set | ☐ | ☐ |
| Student can carry diabetes supplies, determine insulin dose, and self-administer insulin via insulin pen ☐ or insulin pump ☐ | ☐ | ☐ |

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: 4oz. fruit juice or non-diet soda, 3-4 glucose tablets, or tube frosting, snack provided by parent, or other_____
2. Repeat the above treatment until blood glucose is over _____mg/dl. Student may then return to class.
3. Follow treatment with snack of_____grams of carbohydrates if more than 1 hour until next meal/snack or if going to activity.
4. Notify parent when blood glucose is below_____mg/dl.
5. Delay exercise if blood glucose is below _____mg/dl.
6. Delay academic testing 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 Injection:** ☐ 0.5mg ☐ 1mg ☐IM ☐ SQ

☐**Gvoke (glucagon):** ☐HypoPen ☐Prefilled Syringe ☐ 0.5mg ☐ 1mg ☐SQ

☐**Baqsimi (glucagon):** ☐ 3.0mg ☐IN (Intranasal)

☐**Zegalogue (dasiglucagon):** ☐AutoInjector ☐Prefilled Syringe ☐ 0.6mg ☐SQ

| **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 ☐ Yes ☐ No

Students Signs and Symptoms may include: Increase in ☐ Hunger ☐Thirst ☐Urination ☐Headache ☐Stomach Ache ☐Warm, Dry, Flushed Skin ☐Fatigue ☐Blurred Vision ☐Drowsiness ☐Confusion ☐Sweet, Fruity Breath ☐Other: _____

**Management of High Blood Glucose (over_____mg/dl)**

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. Delay academic testing if blood glucose is above _____mg/dl.
8. Retest blood glucose in _____hours if above _____mg/dl.
9. If blood glucose over _____mg/dl, and is not responding to interventions, contact parent for student pick up.
10. 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: ☐Before Breakfast ☐Before Lunch ☐Blood glucose _____mg/dl and has been ____ hours since last insulin dose ☐Other: _____

| **Type of Insulin at school:** | ☐Humalog | ☐Novolog | ☐Other_____ |
|---|---|---|---|

| **Method of Insulin Delivery at school** | ☐ **Insulin Pen** | ☐ **Insulin Pump: Pump will calculate insulin dose.** **Suspend Pump if blood glucose is below_____mg/dl** **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:** | ☐Before Breakfast ☐Before Lunch ☐Before Snack ☐Other: _____ |
| **Insulin Correction Factor** | Give one unit of insulin for every _____ mg/dl that Blood Sugar is Above or Below Target Blood Sugar. |

☐ 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 |
| Blood Sugar _____ to_____ | Insulin- _____ units | Blood Sugar _____ to_____ | Insulin- _____ units |

| Student's Name: | DOB: |
|---|---|

I hereby authorize the above-named Diabetes Healthcare Provider and Bay District Schools, Charter 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, Charter 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.

Parent/Guardian Signature: _____ Date: _____

Physician/Practitioner Signature: _____ Date: _____

## INDEPENDENT/SELF-CARE:

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, the parent/guardian, will complete and return the Individual Care Plan for my child with instructions regarding emergency care.

Parent/Guardian Signature: _____ Date: _____

Reviewed by: _____, School Health Registered Nurse Date: _____

***This section must be signed by a licensed medical provider (physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a podiatric physician licensed under chapter 461, or an advanced practice registered nurse registered under s. 464.0123)***

☐ **Yes** ☐ **No**: Parent/guardian is authorized to increase or decrease the correction dose for hyperglycemia outside of mealtime

☐ **Yes** ☐ **No**: Parent/guardian is authorized to increase or decrease the correction factor within the following range +/- ____ points that the blood glucose is above/below target blood glucose

☐ **Yes** ☐ **No**: Parent/guardian is authorized to increase or decrease carb ratio within the following range: 1 unit per prescribed grams of carb +/- ___ grams of carbohydrate

Student Name: _____ Student DOB: _____
Provider Printed Name: _____
Provider Signature: _____ Date: _____
Parent/guardian Printed Name: _____
Parent/guardian signature: _____ Date: _____