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:

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

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 assistance:

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**
Parents are authorized to adjust insulin dosage* (See Below)	☐ **Yes**	☐ **No**
Parent may adjust insulin/carb ratio* (See Below)	☐ **Yes**	☐ **No**

FOR SLIDING SCALE INSULIN

High BG Levels

For BG levels:
Between _____ – _____
Between _____ – _____
Between _____ – _____
Between _____ – _____
Between _____ – _____
Between _____ – _____
Between _____ – _____
Between _____ – _____

Sliding Scale Insulin
Units_____Type_____
Units_____Type_____
Units_____Type_____
Units_____Type_____
Units_____Type_____
Units_____Type_____
Units_____Type_____
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:

***The District reserves the right, based upon review by the school nurse, to first consult with the physician before proceeding with any adjustments as indicated above.**

Please see other side-

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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 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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