Pasco County Schools
Kurt S. Browning, Superintendent of Schools
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

Dear Parent/Guardian:

According to District School Board of Pasco County Policy 5335, students who receive medication, health procedures or have special dietary needs (e.g. Diabetes Management, Diastat, Asthma Inhaler, EpiPen, Pancreatic Enzyme Supplement) at school shall provide **annual** parental and healthcare provider authorization for the administration of medications and procedures.

If your child plans to carry his/her own supplies and/or perform any of the above medical procedures independently and without supervision during the next school year:

- Please return the *Authorization to Carry and Self Administer Diabetes Medication/Procedure, Asthma Inhaler, EpiPen, Pancreatic Enzyme Supplement* form (available on the district website) signed by physician, parent and student **on or before the first day of school.**
- Please make sure your child carries all necessary supplies (Diabetes equipment or medication, Inhaler, Epipen, and/or Pancreatic enzyme supplement) at all times.

If your child may/will require assistance with administration of medication and/or procedures at any time during the next school year:

- Depending on your child's condition, please return either the *Severe Allergy (Anaphylaxis)* ***or*** *Seizure* ***or*** *Diabetes Medical Management Plan* form (found below) completed and signed by physician and parent **on or before the first day of school.**
- Please return the *Authorization for Medication Administration* form (available on the district website) for any medication that will need to be administered for your child **on or before the first day of school.** This form should be completed and signed by parent.
- Please provide the school clinic with all necessary supplies. Remember that medication must be brought to school by the parent / guardian (e.g. Insulin, Glucagon, Diastat, Inhaler, Epipen, etc.).

If your child may/will require assistance with special dietary needs during the next school year:

- Please submit completed *Diet Order Request* and/or *Severe Allergy (Anaphylaxis) Medical Management Plan* forms. The *Diet Order Request Form* will be reviewed/evaluated by the Food & Nutrition Services District Office on a case-by-case basis. Since school sites are not allergen free facilities, it may be beneficial to send a meal from home for the first few weeks of school.

While not all students' requests will be accommodated, our online menus identify common allergens and carbohydrate/nutrient information to assist you and your child in navigating their meal options. You can access this helpful tool online at https://schools.mealviewer.com/results/pasco%20county or download the mobile app on your smartphone or tablet.

Please feel free to call your child's School Nurse if you have any questions or would like to discuss your child's health status.

Thank you.

Pasco County School Health Services Program

4/2022

Pasco County Schools

General Guidelines for Administration of Medication at School

1. Administration of medication during school hours should occur only when medication schedules cannot be adjusted to provide for administration at home.
2. Medication will be administered by personnel trained by the registered professional school nurse.
3. Medication must be brought to school by the parent/guardian in the original prescription container with the original prescription label containing the following information:
    a. Student's name.
    b. Name of medication (Only FDA approved [regulated] medications will be administered at school, i.e., no herbal medications, supplements, essential oils, etc.).
    c. Dosage prescribed (If the dosage changes a new prescription bottle or script must be provided).
    d. Time of day to be taken (e.g., 9:45 AM) or if the medication is ordered as needed, how many hours in between doses (e.g., every 2 hours).
    e. Physician's name.
    f. Special instructions.
    g. Date of prescription (current, within one year).
4. No more than a month's supply (30-day supply) of medications should be brought to school by a parent/guardian, at one time.
5. All medications, whether self-carry or maintained in the clinic must be entered into the Health – Clinic System Medication Order Form. Medications administered in the clinic will be recorded on the Medication Administration Record (MAR) / Medication Inventory Record (MIR) and in the Health – Clinic System. Any changes to the time or dosage requires a new MAR / MIR to be created and a discontinuation of the Medication Order Form and a new Medication Order Form will need to be created with the updated information.
6. Medication received must be counted by at least two trained staff (additional signature from parent preferred). The amount and date received is to be recorded in the Health – Clinic System and on the individual *Medication Inventory Record* form.
7. A *Parent/Guardian Permission* form must be completed by the parent/guardian, granting the school permission to assist in the administration of such medication and which shall explain the necessity for such medication to be provided during the school day, including any occasion when the student is away from school property on official school business. Parents may not need to complete this form if authorization is provided (signed by parent/guardian) via student's *Medical Management Plan*.

*Note: It is preferred that the parent/guardian of a student obtain the needed dose(s) of medication for field trips in a separate, appropriately labeled prescription container. If that is not possible, the entire bottle of medication must be sent with a trained person to be administered on the field trip. Under no circumstances may medication be transferred from one container to another by anyone other than a registered pharmacist (no medications are to be placed in envelopes or baggies).

8. FDA approved (regulated), over-the-counter medication will not be administered at school, unless accompanied by a physician's statement, dated within the current school year (exception: *Healthy Student Program*). Over-the-counter medications must be brought to school by a parent/guardian in the original, unopened container.
9. Students will be allowed to carry metered dose asthma inhalers, pancreatic enzyme supplements, epinephrine auto-injectors and/or diabetes supplies, medication, and equipment with a completed *Authorization to Carry and Self Administer* form from their parent/guardian and physician (F.S.1002.20 (3)(h), (i), (k) and/or (j)).
10. If a student is participating in an after-school activity and has emergency medication in the clinic, the registered professional school nurse and clinic assistant must be notified by the parent/student.
11. No prescription narcotic analgesics will be administered at school.
12. Parental and healthcare provider authorization for the administration of medications and treatments is required each school year.
13. All medications must be removed from the school premises one week after the expiration date, upon appropriate notification of medication being discontinued, or at the end of the school year. If not retrieved by a parent/guardian or designee, unused and unclaimed medication will be destroyed following proper disposal procedures. Legal Authority: section 1006.062, F.S.A.

Legal Authority: section 1006.062, F.S.A.

Pasco County Schools
Parent/Guardian Medication Administration Permission Form

I have read Pasco County Schools' *General Guidelines for Administration of Medication at School* and permission is hereby granted to _____ Pasco County Schools'
(Name of school)
trained personnel to administer the following medication to:

_____
(Student's name) (Student #) (Grade) (DOB)

for the treatment of _____.
(Health condition)

Name of prescribing Health Care Provider: _____

Known Allergies: _____

Name of medication: _____

Dose of medication: _____ Route of medication: _____ Time to be given at school: _____

Special instructions (including reasons for which medication must be administered during the school day or at after school activities): _____

_____

Possible reactions / side effects: _____

_____

I hereby authorize designated Pasco County Schools' staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health 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 hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant to the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed each school year.

_____ Date: _____
(Signature of Parent / Guardian)

Note: Give parent copy of *General Guidelines for Administration of Medication at School*

FNS REQUEST
for Special Nutritional Needs
Annual Medical Statement for Students

DO NOT WRITE IN THIS AREA
9532049620

School Year: _____ *(Año escolar)*

PART A Parent / Guardian: Complete Items 1 - 16 *(Padre/madre/tutor: complete la información en los espacios 1 al 16)*

1) **Student ID#** *(Numero de estudiante)* | 2) **Student's Last Name** *(Apellido)* | 3) **Student's First Name** *(Nombre del estudiante)* | 4) **Date of Birth** *(Fecha de nacimiento)*

5) **School** *(Escuela)* | 6) **Grade** *(Grado)* | 7) **Student assigned in:** ☐ PreK/EHS ☐ PreK VE ☐ Charter ☐ K-12

Parent/Guardian Name & Contact Information ***(Nombre & Información del contacto)***

8) Name *(Nombre)* | 9) Phone Number *(Teléfono)* | 10) Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

11) E-mail Address (We will use this to send acknowledgement and details of your child´s menú plan. PRINT NEATLY)
Dirección electrónica (será usada para acuso de recibo y detalles sobre el menú de su niño. IMPRIMA)

12) **Meals Eaten at School**
(Los alimentos que su niño(a) consumirá en la escuela)
☐ **Breakfast** *(Desayuno)* ☐ **Snack** *(Meriendao)*
☐ **Lunch** *(Almuerzo)* ☐ **None** *(Nada)*

13) **Allowable Parent Request:** *(Solicitud de los padres)*
☐ **Lactose Intolerance** *(intolerancia a lactosa)* *(Lactaid Milk needed) (necesita leche Lactaid)*
Mark if student cannot eat (marque si no puede comer) ☐ **Cheese** *(queso)* ☐ **Yogurt** *(yogur)*
☐ **Cultural/Religious Preference** *(preferencias culturales/religiosas)*
Mark if student cannot eat (marque si no puede comer) ☐ **Pork** *(carne de cerdo)* ☐ **Beef** *(carne de res)* ☐ **Other** *(otro)* _____
☐ **Other Condition (Must be diagnosed by physician using Part B)** *(Otro condición- debe ser diagnosticado por un médico en la parte B)*

14) **Does the student have an identified disability (IEP or 504 Plan)?**
¿Ha sido el estudiante identificado con una discapacidad (PEI o Plan 504)? ☐ Yes *(Sí)* ☐ No

15) **I consent to the exchange of information between the physician and school, as needed.**
(Doy mi consentimiento para que la información sea intercambiada entre el médico y la escuela, según sea necesario)
Parent / Guardian Signature (required for processing) ***(Firma del padre/madre/tutor** - requerido para ser procesado)* X _____ **Date** *(Fecha)* _____

16) **Parent/Guardian: It is REQUIRED that this completed form is returned to the cafeteria manager. All further changes to the child's diet must be made by a physician on a new form with the exception of lactose intolerance or cultural preference. The manager will add the alert to the cashier system & return the form to the District FNS Office for consideration.**
(Padre/madre/tutor: Se REQUIERE que se devuelva la forma debidamente completada al gerente de la cafetería. Cualquier cambio en la dieta del estudiante debe ser hecho por un médico en una nueva forma, a excepción de la intolerancia a lactosa o preferencias culturales. El gerente de la cafetería añadirá un alerta en el sistema de cajeros y devolverá la forma a las oficinas de Alimentos y Nutrición del Distrito)

*Information regarding major allergens and nutrient/carbohydrate information are available for review at http://schools.mealviewer.com/district/pascocounty
(Ver información sobre alergenos y nutrientes/carbohidratos en http://schools.mealviewer.com/district/pascocounty)

PART B COMPLETED BY THE PHYSICIAN ONLY: Complete Items 17 – 20 *(17 al 20 - Esta sección para ser completada por el médico solamente.)*

17) **Student Diagnosis or Condition** ☐ Food Intolerance ☐ Food Allergy ☐ *Life Threatening Food Allergy ☐ Other (Specify) _____
**** Students with life threatening food allergies must have an emergency action plan in place at school.***

18) **Please check all food(s) to omit from child's diet during the school only (not to be used as a medical history):**

DAIRY
- ☐ Fluid Milk. Substitute with ☐ lactose-free milk ☐ soy milk ☐ water
- ☐ Cheese and recipes with cheese listed as an ingredient
- ☐ Ice Cream
- ☐ Yogurt
- ☐ Baked goods with any dairy listed as an ingredient

EGG
- ☐ Whole eggs such as scrambled eggs or hard cooked eggs
- ☐ Baked goods with any egg listed as an ingredient

WHEAT / GLUTEN
- ☐ Recipes with any wheat listed as an ingredient
- ☐ Recipes with any gluten containing grain listed as an ingredient

FISH OR SHELLFISH
- ☐ Fish ☐ Shellfish

PEANUTS OR TREE NUTS
- ☐ Peanuts
- ☐ Tree Nuts

CORN
- ☐ Whole corn such as corn kernels, tortilla chips, corn muffin
- ☐ Recipes with corn / corn products listed as an ingredient

SOY
- ☐ Soy Lecithin
- ☐ Soy Protein (concentrate, hydrolyzed, isolate)
- ☐ Recipes with any soy listed as an ingredient

OTHER
- ☐ Other, specify if it is a cooked ingredient or when consumed fresh

_____
_____

19) **Does the student have a disability, medical condition, or severe food allergy warranting a special diet?** ☐ **Yes** If "YES", specify disability below
A disability is defined as a physical or mental impairment which substantially limits one or more major life activities. ☐ **No** **If "NO", A SPECIAL DIET IS NOT WARRANTED.**

Disability (specify) _____ Describe major life activities affected _____

FOOD TEXTURE MODIFICATION If medically needed check ONE: ☐ Pureed ☐ Ground ☐ Chopped

20) **LICENSED PHYSICIAN'S INFORMATION** ***Diet Order Form will be returned to parent / guardian and NO accommodations will be made if this section is not filled in its entirety.***

Medical Authority Signature: X _____ Date: ☐☐ - ☐☐ - 202☐

Medical Authority Printed Name _____

Medical Office Stamp (Required for processing)

Pasco County Schools

Anaphylaxis Medical Management Plan

Student Name:	D.O.B:	School Year:
Allergy to:	Asthma: _____Yes *higher risk for severe reaction _____ No	
Other health problems besides anaphylaxis	Other medications:	

Symptoms of Anaphylaxis

Mouth	Itching, swelling of lips and/or tongue
Throat*	Itching, tightness/closure, hoarseness
Skin	Itching, hives, redness, swelling
GI:	Vomiting, diarrhea, cramps
Lung*	Shortness of breath, cough, wheeze
Heart*	Weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
*Some symptoms can be life threatening. **ACT FAST!**

Emergency Action Steps

DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

_____ Epi-pen Jr. (0.15 mg.) _____ Epi-pen (0.3 mg.)
_____ Adrenaclick (0.15 mg.) _____ Adrenaclick (0.3 mg.)
_____ Auvi-Q (0.15 mg.) _____ Auvi-Q (0.3 mg.)

Epinephrine injection, USP Auto-injector – authorized generic
_____ (0.15 mg.) _____ (0.3 mg.)
Other (specify): _____

ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS!

2. Call 911 immediately! Call emergency contacts next.
3. Emergency contact #1: home_____work_____cell_____

   Emergency contact #2: home_____work_____cell_____

Parent has provided emergency medication to school: ☐ YES ☐ NO

I hereby authorize the above-named physician and Pasco County School's staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health 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 hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

Print, type, or stamp Physician's Name & Information: _____

Address: _____ Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Adapted from American Academy of Allergy, Asthma & Immunology www.aaaai.org.

Revised 5/2022

Pasco County Schools

Asthma Medical Management Plan

Student's Name:	Student ID:	DOB	School Year
School:		Grade:	Home Room:
Parent/Guardian #1:	Home #:	Cell #:	Work #:
Parent/Guardian #2:	Home #:	Cell #:	Work #:
Parent/Guardian E-Mail Address:			
Healthcare Provider(s):		Phone #:	Fax #:

Green Zone: Go!

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow: _____ to _____
(More than 80% of Personal Best)

Personal best peak flow _____

Take these CONTROL (PREVENTION) Medicines EVERY DAY

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

☐ No control medicines required.

☐ Dulera ☐ Symbicort ☐ Advair ____ Puff(s) ____ Times a day
Combination medications inhaled corticosteroid with long-acting β-2-agonist

☐ Alvesco ☐ Asmanex ☐ Azmacort ☐ Flovent ☐ Pulmicort ☐ QVAR
Inhaled Corticosteroid or inhaled corticosteroid/long-acting β-2-agonist

____ Puff(s) MDI _____ times a day Or ____ nebulizer treatments(s) ____ times a day
☐ Singulair or, _____ Take _____ By mouth once daily at bedtime Leukotriene antagonist

For asthma with exercise, ADD: ☐ Albuterol or _____, _____ Puffs with spacer 15 minutes before exercise

Yellow Zone: Caution!

You have **ANY** of these:
- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Can do some, but not all of usual activities.

Peak flow in this area:
_____ to _____
(50% - 80% of Personal Best)

Continue CONTROL Medicines and ADD RESCUE Medicines

_____, _____ Puff(s) MDI **with spacer** every _____ hours as needed
Fast-acting inhaled β-agonist

OR

_____, _____ nebulizer treatment(s) every _____ hours as needed
Fast – acting inhaled β-agonist

IF SYMPTOMS PERSIST MOVE TO RED ZONE – EMERGENCY!

Red Zone: EMERGENCY

You have **ANY** of these:
- Can't talk, eat or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area:
Less than: _____
(less than 50% of Personal Best)

Continue CONTROL & RESCUE Medicines and **GET HELP!**

_____, _____ Puff(s) MDI with spacer every _____ Minutes, for _____ treatments
Fast-acting inhaled β-agonist

OR

_____, _____ Nebulizer treatment every _____ Minutes, for _____ treatments
Fast-acting inhaled β-agonist

CALL 911 FOR AN AMBULANCE!

I hereby authorize the above-named physician and Pasco County School's staff to reciprocally release verbal written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health 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 hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant the Parent's Bill of Rights, Chap. 1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

Parent/Guardian Signature: _____ **Date:** _____

Physician's/Mid-Level Practitioner's Signature: _____ **Date:** _____

School Health Registered Nurse Signature: _____ **Date:** _____

Revised 5/2022

Pasco County Schools

Individualized Seizure Action Plan for School Year 20_____ - 20_____

Student's Name: _____	Student ID: _____	DOB: _____	Diagnosis: _____
School: _____		Grade: _____	Home Room: _____
Parent/Guardian #1: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian #2: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian's E-mail Address: _____		Preferred Communication Method: ☐ Phone ☐ Email	
Healthcare Provider: _____		Phone: _____	Fax: _____

Medical Orders (MD, PA, or ARNP who manages student's seizure disorder- complete all sections below and sign)

Seizure History

Date of Onset: _____ Date of Last Known Seizure: _____ Seizure Type: _____

Aura (If known): _____ Can Student Identify Aura: ☐ No ☐ Yes

Does the student understand his/her diagnosis? ☐ No ☐ Yes | Is the student able to identify oncoming seizure activity? ☐ No ☐ Yes

Triggers:	☐ Electronics (Type: _____ ☐ Fire Alarm/Strobe Light ☐ Anxiety/Startling ☐ Illness ☐ Sleep Deprivation ☐ Specific Time of Day/Night: _____ ☐ Nutrional Factors: _____ ☐ Other: _____

Symptoms of Seizure

☐ Staring	☐ Loss of Bower/Bladder Control
☐ Jerking Movement of Arms and Legs	☐ Not Responding to Noise or Words for Brief Periods
☐ Stiffening of the body	☐ Appearing Confused or in a Haze
☐ Breathing difficulties	☐ Nodding Head Rhythmically (Associated with loss of awareness or consciousness)
☐ Loss of Consciousness	☐ Having sudden rapid eye movements
☐ Falling Suddenly	☐ Other: _____

Seizure Management

Emergency Medication: _____	Dose: _____	Route: _____	Administer for seizure lasting longer than _____ minutes.
Emergency Medication: _____	Dose: _____	Route: _____	Administer for seizure lasting longer than _____ minutes.
Daily Medication: _____	Dose: _____	Route: _____	Time of Day: _____

Emergency Medication will be provided by parent: ☐ No ☐ Yes

Implanted Device Type: ☐ N/A ☐ VNS | **Does the student know how to use implanted device?** ☐ No ☐ Yes

VNS instructions (quantity of swipes and frequency): _____

Call 911 for the following:

☐ If seizure continues after giving emergency medication
☐ On onset of seizure
☐ If atypical seizure activity
☐ Other: _____

Call Parent/guardian/emergency contact for the following: _____

Emergency Contact: _____

Student's Name: _____ Student's DOB: _____ Student's ID#_____

Accommodations / Special Considerations: If yes please indicate accommodation(s) or restrictions needed
Is the student allowed to participate in sports? ☐ No ☐ Yes
If yes are there any restrictions? ☐ No ☐ Yes Restrictions:
Any restrictions/Accommodations needed for the following? Classroom Setting: ☐ No ☐ Yes: _____ Recess: ☐ No ☐ Yes: _____ School Activities: ☐ No ☐ Yes: _____ Transportation: ☐ No ☐ Yes: _____ After school programming: ☐ No ☐ Yes: _____ Field Trips: ☐ No ☐ Yes: _____

The medical professional who is completing this document shoud provide in this section additional medical orders not covered on this form:

Physician's/Mid-Level Practitioner's[1] Signature: _____ Date: _____

Place Office Stamp Here

I hereby authorize the above-named physician and Pasco County School's staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protect and secure the privacy of student health 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 hereby authorize and direct that my child's medication or treatment be administered in the manners et forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parents(s)/guardian.
I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant to the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

Parent/Guardian Signature: _____ Date: _____

School Health Registered Nurse Signature: _____ Date: _____

[1] In accordance with 1006.0626, FL Stat., this form must be executed by a Physician or Physician Assistant (licensed under Chap. 458 or 459, FL Stat.), or an Advanced Practiced Registered Nurse (licensed under Section 464.012, FL Stat. and who provides epilepsy or seizure disorder care to the student).

Pasco County Schools

Diabetes Medical Management Plan for School Year 20____ - 20____

Student's Name:	Student ID	DOB:	Diabetes Type:
Date Diagnosed: _____ (or fill in here: _____) Year: _____			
School: _____		Grade: _____	Home Room: _____
Parent/Guardian #1: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian #2: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian's E-mail Address: _____			
Diabetes Healthcare Provider: _____		Phone: _____	Fax: _____

Student's Self-Management Skills	Independent	Needs Supervision	Full Support By Trained Staff
Performs Testing and Interprets Blood Glucose/CGM Results	☐	☐	☐
Calculates Carbohydrate Grams	☐	☐	☐
Determines Insulin Dose for Carbohydrate Intake	☐	☐	☐
Determines Correction Dose of Insulin for High Blood Glucose	☐	☐	☐
Determines insulin dose and self-administer insulin	☐	☐	☐
Student allowed to carry diabetes supplies	☐	*Students who require no supervision are allowed to carry diabetes supplies and self-administer insulin with written parental and physician authorization, according to Florida Statute 1002.20(3)(j).*	

Testing Blood Glucose At School

Test Blood Glucose before administering insulin and as needed for signs/symptoms of high/low blood glucose.

Additional Blood Glucose Testing at school: ☐ Yes (Time/s): _____ ☐ Before Exercise ☐ Before Dismissal **OR ▶** ☐ No

Target Range for Blood Glucose: _____ mg/dl to _____

Continuous Glucose Monitors (CGM)

Student uses continuous glucose monitoring system at school: ☐ Yes **OR ▶** ☐ No. Make/Model:

Alarms set for: Low _____ mg/dl High _____ mg/dl ***If sensor falls out at school, notify parent***

☐ May use CGM reading in place of BG finger stick for calculating correction if CGM reading is between _____ or _____ **OR ▶** ☐ No

Students using a continuous glucose monitor must always do fingerstick glucose reading to confirm a low/high blood glucose and/or if symptomatic.

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

Does student recognize signs of **LOW** blood glucose? ☐ Yes or ☐ No

Student's usual symptoms of hypoglycemia.

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

1. If student is awake and able to swallow: give _____grams fast-acting carbohydrates such as: 4 oz. fruit juice or non-diet soda or 3-4 glucose tablets or concentrated gel or Other: _____
2. Retest blood glucose 10-15 minutes after treatment. Student remains in clinic during treatment.
3. Repeat the above treatment until blood glucose is over _____ mg/dl.
4. Follow treatment with snack of _____ grams of carbohydrates if more than one 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/d

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

☐ **Glucose gel:** One tube administered inside cheek and massaged from outside while waiting or during administration of Glucagon.
☐ **Glucagon: _____ mg** by subcutaneous or intramuscular injection
☐ **Baqsimi Nasal Spray: 3 mg**
☐ **Gvoke HypoPen: _____ mg** by subcutaneous injection ☐ **Gvoke PFS: _____ mg** by subcutaneous injection
☐ **Gvoke Kit (1mg/0.2ml)** by subcutaneous injection

Physician's Signature _____ Date _____

Student's Name: _____ Student's DOB: _____

HIGH Blood Glucose (HYPER-glycemia)

Does student recognize signs of **HIGH** blood glucose? ☐ Yes ☐ No

Student's usual symptoms of hyperglycemia: _____

Management of High Blood Glucose (over _____ mg/dl)

Students using a continuous glucose monitor must always do fingerstick glucose reading to confirm a high blood glucose.

Refer to the **Insulin Administration** section below for designated times insulin may be given.

1. Give water or other calorie-free liquids as tolerated and allow frequent bathroom privileges.
2. Check **ketones** if blood glucose over _____ mg/dl.
3. Notify parent if **ketones** positive and/or glucose over _____ mg/dl. **If moderate/large ketones notify the parent to pick up the child.**

In addition to steps above for management of high blood glucose, also follow steps below for very high blood glucose over _____ mg/dl.

4. If unable to reach parents, call diabetes care provider. (Medical orders must be in writing. No verbal orders accepted.)
5. If unable to reach parents or physician stay with student and document changes in status. Call 911 for labored breathing, very weak, confused or unconscious.
6. Retest blood glucose in _____ hours if above _____ mg/dl.
7. Delay exercise if blood glucose is above _____mg/dl.

Insulin Administration

Insulin administration at school, indicate times: ☐ Before Breakfast ☐ Before Lunch ☐ Snack ☐ High Blood Glucose Correction

Insulin correction dose for high blood glucose greater than _____mg/dl **AND** at least ____**hours** since last insulin dose, give correction dose of insulin (see correction dose below).

☐ Whole unit insulin rounding: If insulin dose comes to **0.1 - 0.4 units round down**. If insulin dose comes to **0.5 - 0.9 units round up**.

Type of Insulin at school:	☐ Humalog	☐ Novolog	☐ Apidra	☐ NPH	☐ Lantus	☐ Levemir	☐ Other: ____

Method of Insulin delivery at school:	☐ **Pen** ☐ **Syringe**	☐ **Insulin Pump: Pump will calculate insulin dose.** If pump fails, use **pen/syringe** to administer insulin per sliding scale or correction dose below. Indication of possible pump failure is **BG ≥ 250 and moderate or large ketones.**

Carbohydrate Insulin Dose

Insulin for ***carbohydrates*** eaten at school, indicate times:

☐ Before Breakfast Give one unit of insulin per _____grams of carbs	☐ Before Lunch Give one unit of insulin per _____ grams of carbs	☐ Snack. If, yes, time/s: _____ ☐ Give one unit of insulin per _____ grams of carbs ☐ Free Snack _____grams

High Blood Glucose Correction Dose – Use Insulin Sliding Scale or Equation

Blood glucose _____ to _____	Insulin Dose = _____units	Blood glucose _____ to _____	Insulin Dose = _____units
Blood glucose _____ to _____	Insulin Dose = _____ units	Blood glucose _____to _____	Insulin Dose = _____ units
Blood glucose _____ to _____	Insulin Dose = _____ units	Blood glucose _____ to _____	Insulin Dose = _____ units

OR Correction dose (Actual BG minus Target BG _____mg/dL) divided by Correction Factor _____ = Correction Dose

I hereby authorize the above-named physician and Pasco County School's staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protect and secure the privacy of student health 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 hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent(s)/guardian. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant to the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent are indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

Physician's/Mid-Level Practitioner's Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

School Health Registered Nurse Signature: _____ **Date:** _____

Place Office Stamp Here