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.

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Diabetic Supply Checklist for School

Physician Orders/Medical Information	•	Diabetes Management Physician orders for school Diabetes Medical Management Plan	Obtain ***yearly*** at your diabetes clinic appointment before school starts
Testing Supplies	•	Blood Testing Supplies	
	•	• Glucose meter	
	•	• Blood test strips	Use within 4 months after opening
	•	• Disposable lancets	
	•	• Control Solution	Use within 6 months after opening
	•	Urine/Blood Testing (Ketostick)	
Hypoglycemia (Low Blood Sugar) Treatment Supplies	•	15 gram ***labeled*** carbohydrate foods for the treatment of Hypoglycemia/ low sugar	Parent responsibility
	•	• Juice box	
	•	• Glucose tablets	
	•	• Regular soda	
	•	• Candy	
		• Protein to follow treatment for hypoglycemia	Parent responsibility
	•	• Glucagon emergency kit	Requires physician prescription Check expiration date
Hyperglycemia (High Blood Sugar) Treatment Supplies	•	Insulin	Check expiration date
	•	Syringes or Insulin Pen needles	
		Pump change of site/batteries	
Personally labeled container or small box for Diabetic supplies	•	Medium container i.e.: 13L x 8.5 W	For organization of supplies at school
Emergency contacts	•	Parents' names, current work, cell & home numbers & alternate contacts	

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

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

AUTHORIZATION TO CARRY DIABETES EQUIPMENT AND SELF ADMINISTER DIABETES MEDICATION/PROCEDURES

Student Name (print) _____ Parent / Guardian Name (print) _____

Student Number _____ Grade _____ Name of School _____

Medication(s)/Procedure(s) _____

In order for your child to carry and administer his/her own diabetes equipment/medication, you must fully complete and return this form **annually** or your child will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out IN ADDITION to the Medical Management Plan, which further sets forth the parental authorization and licensed prescriber's acknowledgement concerning the self-administration of medication.

A. To be completed by the Florida licensed healthcare provider:

_____ has been instructed in the proper use of the above-referenced medication(s) /procedure(s). In my professional opinion, this student is responsible and able to utilize the medication(s) and/or carry out these procedure(s) as directed by me, in the student's Medical Management Plan, without assistance. This student should be allowed to carry and use the diabetes equipment/medication(s) listed above.

(Licensed Prescriber's Signature) (Phone Number) (Date)

B. To be completed by the parent/legal guardian

I request that my child _____ be permitted to carry and self-administer the above-prescribed medication(s)/procedure(s) while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities. My child has been instructed in and understands the purpose, appropriate method, dosage, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication/equipment. My child acknowledges and agrees that the medication/equipment is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action. My child will immediately notify an employee of the District School Board of Pasco County if another student uses his/her medication, equipment, or supplies. My child will immediately notify an employee of the District School Board of Pasco County if and when he/she has any questions, concerns or adverse side effects. It is understood that if there is irresponsible behavior or a safety risk, *the* ***privilege*** of carrying his/her medication will be rescinded. I understand and acknowledge that the District School Board of Pasco County assumes no responsibility whatsoever for the maintenance, storage, dosage, or administration of the above student's diabetes medication/equipment. I furthermore agree to indemnify and otherwise hold harmless the District School Board of Pasco County, its employees and volunteers for any and all liability with respect to the student's use or misuse of such medication/equipment pursuant to s. 1002.20(3)(j).

Date _____ Parent / Guardian Signature _____

Date _____ Student Signature _____

Revised 5/2015

CGM/Blood Glucose Log

Revision 6/2019

Student Name: _____ ID#_____ Teacher:_____ Grade:_____

Parent Contact: _____ Physician Contact:_____

Glucose Range: _____ to_____ Finger stick if CGM reading BELOW_____ or ABOVE_____

Hold Activity until >_____ or <_____

See DMMP for INSULIN ADMINISTRATION for meals/snacks or >_____.

DO NOT GIVE CORRECTION DOSE if insulin given in last ___ hours!

FOR LOW: <_____ Give _____grams of Carbs (ex: 4 oz. juice /soda, 3-4 glucose tabs). Recheck in 10-15 min. Repeat until BG >_____

									Initials Trained Staff	
Date	Time	CGM Reading	Blood Glucose Reading	Carb Count	Insulin Amount Given	Ketone Result	Comments: (food, time of day, exercise, change in routine, academic testing	Parent Notified	Gave insulin or managing care	Witnessed insulin amt. given
								Y / N		
								Y / N		
								Y / N		
								Y / N		
								Y / N		
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								Y / N		
								Y / N		

Signature and Initial:

_____ _____/_____ _____/_____ _____

Medication Inventory Record

Transfer amount of medication from Previous month: ________

Student name: ______________________ Student #: __________ Grade: ____ DOB: __________

Medication: ______________________ Dosage: __________ Time: __________

Date	Time	Start Count	Plus	New Amt Rec'd	Total	Minus	Amt Given	Minus	Wasted or returned / Field Trip	Actual Total W / H	Staff Initials	Staff Initials	Parent Initials	Action Taken Code	Comments	RN
			+			-		-								
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Codes: R = RN Notified, A = Admin Notified, P = Parent Notified, D = Dropped Med, E= Expired Med, F = Field Trip, O = Other

Initials and Signature of persons counting medications

Revised 6/2022