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

Diabetes

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

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' trained personnel to administer the following medication to:

(Name of school)

_____

(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 understa nd 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*

Pasco County Schools

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

Student's Name:	Student ID	DOB:	Diabetes Type:
Date Diagnosed: Select Month from Pulldown (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 administered by trained personnel.

Physician's Signature _____ Date _____

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

HIGH Blood Glucose (HYPERglycemia)

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 correction for ***high blood glucose*** at school, indicate times: ☐ Before Breakfast ☐ Before Lunch ☐ Other time: _____
May NOT repeat insulin correction dose within _____ hours of a correction dose for high blood glucose.

Type of Insulin at school:	☐ Humalog x	☐ 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

FNS REQUEST
for Special Nutritional Needs
Annual Medical Statement for Students

DO NOT WRITE IN THIS AREA
3102479680

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)*
If lactose intolerant, mark if can eat (marque si puede comer) ☐ **Cheese** *(queso)* ☐ **Yogurt** *(yogur)*
☐ **Cultural/Religious Preference** *(preferencias culturales/religiosas)*
☐ **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 *(Si)* ☐ 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 cafeteria. 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 cafeteria 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/cerbohidratos 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 | Date | Medical Office Stamp (Required for processing)

X _____

Medical Authority Printed Name

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

MIS Form #791
Rev. 7/15

DISTRICT SCHOOL BOARD OF PASCO COUNTY

7227 Land O' Lakes Boulevard
Land O' Lakes, Florida 34638

AUTHORIZATION FOR RELEASE OF RECORDS AND/OR INFORMATION FROM RECORDS

Please print or type:

RECORDS TO BE RELEASED TO SLHS School Nurse
Contact Person

School/Agency Sunlake Highschool Phone

Phone: 813-346-1000
Fax: 813-346-1090

Address 3023 Sunlake Blvd. Land O Lakes, FL 34638

RECORDS TO BE RELEASED FROM _____
Name of School/Agency/Person

Address _____

I, _____, do hereby authorize the release of the following

information on _____ _____ _____
Student Name | Date of Birth | Student #

from the above named school/agency/person:

_____Entire Cumulative Record Folder (Applicable for student transfer to another school or system)
_____Exceptional Student Education Records
_____Grades at Time of Withdrawal
_____Grading System
_____Graduation Requirements
_____Home Language Survey
_____Record of Achievements, Special Awards/Activities
_____Other Confidential Records (specify): _____

X Medical/Health Records (including speech, language, hearing, vision reports and immunization records)
_____Official School Transcript
_____Psychiatric Evaluation
_____Psychological/Social Work Reports
_____Standardized Test Scores
X Treatment/Services Plan

AUTHORIZATION FOR EXCHANGE OF INFORMATION/RELEASE OF CLIENT RECORDS

These records will be for the professional use of authorized District School Board of Pasco County personnel only. Records will be used for educational planning, placement, and/or evaluations. Parent permission is not required when records are requested from authorized personnel or from officials of schools/school systems in which the student seeks to enroll (Family Educational Rights and Privacy Act of 1974, FERPA). Records information shall not be released except on the condition that they will not subsequently be transferred to a THIRD PARTY without first obtaining the proper consent of the parent or eligible student.

Conditions of this exchange of information shall be in compliance with federal regulations, the Family Educational Rights and Privacy Act of 1974 (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and all other applicable federal laws, state statutes, State Board of Education Rules, and local School Board policy.

This authorization shall be terminated one year from the date of signature unless otherwise specified. This consent may be revoked by the client/representative at any time. Revocation has no effect on action previously taken.

_____ _____
Signature of Parent/Guardian or Eligible Student | Date

DISTRIBUTION: White-Referral Agency; Canary-Cumulative Folder; Pink-Originator; Goldenrod-Parent