

**MONTGOMERY COUNTY PUBLIC SCHOOLS  
MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**DIABETES TREATMENT PLAN**

**PART I – TO BE COMPLETED BY THE PARENT/GUARDIAN**

I hereby request and authorize Montgomery County Public Schools (MCPS) and Montgomery County Department of Health and Human Services (DHHS) personnel to provide the medically prescribed treatment plan directed by the physician (Part II, below). I agree to release, indemnify, and hold harmless MCPS and DHHS and any of their officers, staff members, employees, or agents from lawsuit, claim, demand, or action, etc. against them for providing this treatment plan to this student, provided MCPS and DHHS staff are following the physician's order as written in Part II, below. I am aware that the treatment plan may be provided by an officer, staff member, employee, or agent of MCPS and/or DHHS who is an unlicensed person who has received training from a licensed health professional.

Student Name : \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ School Name : \_\_\_\_\_

\_\_\_\_\_  
Signature, Parent/Guardian Telephone \_\_\_\_\_ Date \_\_\_\_\_

**PART II – TO BE COMPLETED BY THE PHYSICIAN**

I understand this treatment plan may be administered in MCPS by unlicensed persons. These individuals may be employees of MCPS who volunteer to administer the treatment(s), or the DHHS Health Room Technician. These persons will be trained by the School Community Health Nurse to carry out the specific treatment plan. **Note: The health room technician or other unlicensed person may function as a critical observer (who cannot count carbohydrates, calculate medication dosages or give intramuscular injections) for students in the management of their diabetes.**

Student Name: \_\_\_\_\_ Diagnosis : \_\_\_\_\_

Treatment orders effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

Please check all boxes and complete all spaces that apply and SIGN BELOW:

**1. Student is capable of performing the following:**

- Blood glucose testing
- Ketone testing
- Determining insulin dose
- Insulin administration
- Independently operate insulin pump:
  - with or  without parental direction

**2. Blood Glucose Testing (Target \_\_\_\_ to \_\_\_\_)**

- For suspected hypoglycemia / hyperglycemia
- Before morning snack
- Before lunch
- 2 hours after lunch
- 2 hours after a correction dose
- No blood glucose testing at school
- Other \_\_\_\_\_

**3. Hypoglycemia Treatment:**

- for blood glucose less than \_\_\_\_\_.**
- Give 15 grams fast acting carbohydrates:
  - 4oz. juice, or  1 small tube glucose gel, or
  - # \_\_\_\_\_ glucose tabs, or  other \_\_\_\_\_
- Provide extra protein & carbohydrate snack after treating lows or give snack/meal early
- RETEST blood glucose in 20 minutes - repeat treatment if blood glucose is < \_\_\_\_\_.**
- Administer **Glucagon** injection (for severe hypoglycemia) use MCPS Medication Form 525-13.

**4. Snacks**

- Mandatory
- AM \_\_\_\_\_
- PM \_\_\_\_\_
- At student's discretion

**5. Hyperglycemia Treatment**

- Encourage fluids / liberal bathroom privileges
- Do ketone testing if blood glucose > \_\_\_\_\_.
- If ketone testing positive:
  - call parent
  - call MD
  - send home
- Other \_\_\_\_\_

**6. Exercise:**

- No exercise (most recent blood glucose < \_\_\_\_.)
- No exercise when blood glucose is > \_\_\_\_\_ or ketones are present.
- Other \_\_\_\_\_

\_\_\_\_\_  
Physician Signature Date

**PART III – TO BE COMPLETED BY THE PRINCIPAL/SCHOOL COMMUNITY HEALTH NURSE**

Part I and II above are completed including signatures.

\_\_\_\_\_  
Signature, Principal/School Community Health Nurse Date Telephone \_\_\_\_\_