DIABETES MANAGEMENT PLAN

Student's Name	Date of Birth	Building/Grade	School Year

Instructions: Parent/Guardian and Provider: Please complete this Diabetes Management Plan and medication orders and return them to the school. Please notify the school with any changes.

Blood glucose monitoring: Student can perform own blood glucose checks (with/without supervision)

Times to check blood glucose: ______with symptoms of low/high blood glucose
______with lunch (see snacks below)
______before dismissal
______other____
______student may carry own meter and supplies with them

Target range ____________to____________mg/d

Hypoglycemia Treatment: 2-4 glucose tablets or
(low blood sugar <______) 4 oz juice or 6 oz soda (not diet or low cal)
shaky, sweaty, change in behavior — Glucose gel -(place between cheek & gum in mouth) - 1/2-1 tube
Follow treatment with 15 gm snack or meal within 1 hour

Severe Hypoglycemia Treatment: _____give glucagon (subq in arm or thigh)
(severe low blood sugar, with unconsciousness, seizures) — dose_____0.5mg (under 44#) _____1.0mg (over 44#)
_____**call 911**; notify parent/guardian

Hyperglycemia Treatment: ______provide water & flexible bathroom privileges
(high blood sugar >_____ — ______test urine for ketones if blood glucose greater than________
increased thirst/dry mouth — ______call parent if ketones are moderate or large
frequent urination) — ______see below for insulin instructions if applicable
______check pump (if applicable) for proper functioning

Insulin: ______Student not taking insulin at school
______Student takes insulin at school

_____insulin injections ______Humalog ______Novolog _______other__________________________
_____Insulin/pump ______meal coverage: ______units/per ______gm carbohydrates
____Insulin w/lunch ______correction scale: If BS >______add _______units
____Insulin w/snacks If BS >______add _______units
If BS >______add _______units
_____student may give own injections If BS >______add _______units
_____student may give own pump boluses If BS >______add _______units
_____student may determine correct dose of insulin
_____student needs assistance with insulin administration
_____student may carry insulin with them

***For parties/special occasions, contact parent**

Snacks: _____Please allow a _____ gram snack at _____ am _____ with coverage _____w/o coverage
_____Please allow a _____ gram snack at _____ am _____ with coverage _____w/o coverage
_____Please allow a 15 gram snack prior to gym class if blood glucose <100

PARENT/GUARDIAN TO PROVIDE SCHOOL WITH CHANGES IN DIABETES MANAGEMENT

Parent will be contacted for dose confirmation or with blood sugar <70 or >400.

Parent signature:___________________________ Emergency Phone:_______________ Date_________________
Provider name(print)________________________ Address__________________________________ Phone____________________
Provider signature____________________________________ Date________________ Fax__________________

Return form to school office. Thank you.