



Diabetes Management Plan

Last Name (legal):	First Name (legal):	Date of Birth:	Grade:	School:

Blood Glucose Target Range	
Blood Glucose Testing Times:	<input type="checkbox"/> Pre-snack <input type="checkbox"/> Pre-lunch <input type="checkbox"/> Pre-dismissal <input type="checkbox"/> Pre-phy. ed. <input type="checkbox"/> Other _____
Breakfast/Snack/Lunch Bolus:	_____ # of units per _____ grams of carbohydrates <input type="checkbox"/> per pump
Correction Scale:	_____ unit per _____ blood glucose points over _____ (See "Correction Scale" below) <input type="checkbox"/> per pump
Student can self-administer insulin/manipulate pump:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Parent may adjust insulin doses as needed:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Student wears a continuous glucose sensor	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Medications: please list all medications student is taking

Medication Name:	Strength:	Dose:	Time:	Route:	Possible Side Effects:

"CORRECTION Scale" – for Hyperglycemia (a "Correction" bolus, ONLY given 3 hour after last correction bolus)	Hypoglycemia Treatment								
<p>High Blood Glucose > _____ mg/dl</p> <p><input type="checkbox"/> Per Pump <input type="checkbox"/> Correction Insulin</p> <table border="0"> <tr> <td>Blood Glucose</td> <td>Units of Insulin</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table> <p><input type="checkbox"/> Administer insulin per "Correction Scale" if more than 3 hours since last correction injection/bolus.</p> <p><input type="checkbox"/> Check ketones if blood glucose is > 300 3 hours since last correction. Notify parents if ketones are present.</p> <p><input type="checkbox"/> Notify parent of blood glucose > _____.</p> <p><input type="checkbox"/> Additional instructions _____</p>	Blood Glucose	Units of Insulin	_____	_____	_____	_____	_____	_____	<p>Low Blood Glucose < _____ mg/dl</p> <p><input type="checkbox"/> Immediately treat with 15 grams of fast-acting carbs (ex: 4 oz. juice or regular pop, 3-4 glucose tablets, fruit snack, 8 oz. skim milk, etc.)</p> <p><input type="checkbox"/> Recheck blood glucose in _____ minutes and repeat treatment if blood glucose remains low.</p> <p><input type="checkbox"/> If student will participate in additional exercise before next meal, student should have another 15 grams of carbohydrates to prevent hypoglycemia.</p> <p><input type="checkbox"/> Notify parent/guardian of blood glucose < _____ mg/dL.</p> <p><input type="checkbox"/> Immediately administer Glucagon _____ mg if student is unconscious or having seizures. Place students on their side as they may vomit. Call 911.</p> <p><input type="checkbox"/> Additional Instructions:</p>
Blood Glucose	Units of Insulin								
_____	_____								
_____	_____								
_____	_____								

Physician's Printed Name:	Signature:	Date:



Parent/Guardian Information:

Parent/Guardian #1			Parent/Guardian #2		
Legal Last Name:	Legal First Name:	MI:	Legal Last Name:	Legal First Name:	MI:
Phone #1:	Phone #2:		Phone #1:	Phone #2:	

FIELD TRIPS: • All testing supplies, snacks for hypoglycemia, and, if needed, a copy of your doctor's orders or our district's Diabetes Care Plan will be sent.

- Specific testing times and insulin administration instructions will be determined for field trips.
- If supplied by parents, glucagon will be sent along on the field trip to be used by 911 personnel, or by a school staff person, who has been trained by the Licensed School Nurse/RN -- and has been delegated the task of giving glucagon.

PARENT /GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

- I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
- I give permission for the medication(s) to be given by school personnel as delegated by the School nurse.
- If my child has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my child. I will notify Health Services if I prefer to pick up the medication(s) at school.
- I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
- I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical conditions(s) being treated by the medication(s).
- I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.
- I release school personnel from liability in the event adverse reactions result from taking the medication(s).
- **Transportation: It is the parent's responsibility to notify the transportation company directly of any specific directions for your child's care while riding transportation during the school day**

NOTE: Medication must be supplied in the original prescription bottle.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Authorization for Management Plan: I understand that this care plan may be revoked at any time in writing, and expires in one calendar year. I authorize the above plan to be followed in school.

Printed Name:	Signature:	Date: