DIABETES MEDICAL MANAGEMENT PLAN

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

Instructions: Parent/Guardian and Provider please complete and sign this Diabetes Medical Management Plan, or provide your own, and return it to school. Parents must provide written documentation to any changes in this plan.

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

TARGET RANGE FOR BLOOD SUGAR IS
_____

Times to check blood glucose:
_____with symptoms of high or low blood glucose
_____with lunch _____with snacks
_____before exercise _____ at dismissal
_____ student may test in classroom
_____student may carry own meter and supplies with ther

Hypoglycemia Treatment:
blood sugar < _____
shaky, sweaty, change in behavior

_____ 3 or 4 glucose tablets or
4 oz juice (juice box) or 6 oz soda (not diet or low cal)
Glucose gel -(place between cheek & gum in mouth) - 1/2-1 tube
If lunch or dinner time, give meal ASAP
If no meal or snack within an hour, then follow up with 15 gm snack

Severe Hypoglycemia Treatmen
severe low blood sugar, with unconsciousness, seizures

_____give glucagon ___0.5mg / ___1.0mg (subq in arm or thigh)
_____**call 911**; notify parent/guardian

Hyperglycemia Treatment:
blood sugar > _____
increased thirst/dry mouth
frequent urination)

_____provide water & flexible bathroom privileges
_____test urine for ketones if blood glucose greater than_____
_____call parent if ketones are moderate or large
_____see below for insulin instructions if applicable
_____check pump (if applicable) for proper functioning

Insulin: _____Student takes insulin at school _____Student not taking insulin at school
_____Humalog _____Novolog _____other_____
____insulin injections
____Insulin/pump _____meal coverage: _____units/per _____gm carbohydrates
____Insulin w/lunch _____correction scale: If BS >_____add _____units
____Insulin w/snacks 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 If BS >_____add _____units
____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 blood sugar <80 or >300.

Parent signature:_____ Emergency Phone:_____ Date_____
Provider name(print)_____ Address_____ Phone_____
Provider signature_____ Date_____ Fax_____

Return form to school office. Thank you.