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.

TARGET RANGE FOR BLOOD SUGAR IS
____

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

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.