Diabetes Management Plan

A physician should complete the information on this page. A parent should complete page 2.

Student Information:

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

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:	

Blood Glucose Monitoring and Insulin:

Blood Glucose Target Number/Range:	
Blood Glucose Testing Times:	☐ Pre-snack ☐ Pre-lunch ☐ Pre-dismissal ☐ Pre-phy. ed. ☐ Other ________
Snack/Lunch Bolus:	______# of units per ______grams of carbohydrates ☐ per pump
Correction Scale:	______unit per _____blood glucose points over _____ (See "Correction Scale" below) ☐ per pump
Student can self-administer insulin/manipulate pump:	☐ Yes ☐ No
Parent may adjust insulin doses as needed:	☐ Yes ☐ No
Student wears a continuous glucose sensor	☐ Yes ☐ No

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)

High Blood Glucose > _______________ mg/dl

☐ Per Pump ☐ Correction Insulin (in addition to scheduled meal dose)

BG Value	**Units of Insulin**
Less than _____	________
______-_______	________
______-_______	________
______-_______	________
______-_______	________
______-_______	________
______-_______	________
______-_______	________
More than ____	________

- ☐ Administer insulin per "Correction Scale" if more than 3 hours since last correction injection/bolus.
- ☐ Recheck blood glucose level in 1 hour if blood glucose is > _____.
- ☐ Check ketones if blood glucose is > 300 twice. Notify parent if ketones are present.
- ☐ Notify parent of blood glucose >___________.
- ☐ Additional instructions ___________________________________

Hypoglycemia Treatment

Low Blood Glucose < _______________ mg/dl

Immediately treat with 15 g of fast-acting carbohydrate (ex: 4 oz. juice, 3-4 glucose tabs, fruit snack, etc.)

- ☐ Recheck BG in 15 minutes and repeat treatment if blood glucose remains low.
- ☐ If student will participate in additional exercise before next meal, student should have another 15 g of carb to prevent hypoglycemia.
- ☐ Notify parent of BG < _________.
- ☐ Immediately administer Glucagon ____ mg if student is unconscious or having seizures.
  - Place student on their side as vomiting is a common side effect.
  - **Call 911.**
  - Notify parent.
- ☐ Additional instructions _______________________________________

Physician's Authorization: I authorize the above plan to be followed at school

Physician's Printed Name:	Signature:	Date:

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

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 trip.
- If supplied by parent, 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

1. 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.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s), i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the School nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I will pick up the medication(s) from the office.

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

Parent/Guardian Signature ____ Date ______________________________

PARENT/GUARDIAN AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
2. 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).
3. 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.

Parent/Guardian Signature _______________________________________ Date ______________________________

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

Printed Name:	Signature:	Date: