DIABETES SCHOOL MANAGEMENT PLAN

DEMOGRAPHICS **DATE OF PLAN:**

Student Name:	DOB:
Parent/Guardian:	
Phone:	Cell phone:
Physician:	Phone & Fax:
Other Emergency Contact Person:	Phone:

CHECKING BLOOD GLUCOSE **(PLEASE CIRCLE CHOICE / FILL IN THE BLANKS)**

Student is: INDEPENDENT IN CARE NEEDS SUPERVISION NURSE MUST PERFORM

When to test: BEFORE MEALS AS NEEDED/REQUESTED BEFORE A SNACK
BEFORE EXERCISE AFTER EXERCISE
OTHER: specify ____

Target range for blood sugar readings: 70-150 70-180 OTHER: ____________________

When **hypoglycemic**, usual symptoms include: ____________________________________

If symptomatic hypoglycemia OR if blood glucose reading is less than _________mg/dL, give quick acting glucose product equal to __________grams of carbohydrate, recheck blood glucose in 10-15 minutes and repeat treatment as needed. Parent notification and doctor's order followed.

If student is unable to eat/drink, is unconscious or unresponsive, is having seizure activity – glucagon will be administered per doctor order and 911, parents, and doctor will be notified	List acceptable quick acting glucose supplies/snacks for your child (please note it is the parent responsibility to provide these for the school): ______________________________

When **hyperglycemic**, usual symptoms include: ____________________________________

For blood glucose greater than __________mg/dL: (circle) TEST KETONES NOTIFY PARENT

ENCOURAGE _______ OUNCES OF WATER OTHER (specify): ____________________

Check urine ketones every _______ hours when blood glucose levels are above __________mg/dL
Parent notification.

Other comment/treatment/limitation:

INSULIN ADMINISTRATION (PLEASE CIRCLE)

Student is: INDEPENDENT IN CARE NEEDS SUPERVISION NURSE MUST PERFORM
Before meals insulin will be administered as per doctor's order, please update any changes in doctor's orders immediately so that appropriate dosing is given.
Other Comment/Treatment/Limitation:

CARBOHYDRATE COUNTING & MEALS/SNACKS AT SCHOOL
(PLEASE CIRCLE / FILL IN THE BLANKS)

Student is: INDEPENDENT IN CARE NEEDS SUPERVISION NURSE MUST CALCULATE
School Breakfast: CARB COVERAGE SLIDING SCALE OTHER: ____________________
Please specify any breakfast limits for carbohydrate content, restricted food or drink items, or other related comment/treatment/limitation:
School Lunch Insulin: CARB COVERAGE SLIDING SCALE OTHER: ____________________
Please specify any lunch limits for carbohydrate content, restricted food or drink items, or other related comment/treatment/limitation (school food list with carb counts provided to parents):
School Snacks: Student MAY / MAY NOT be included in snacks supplied for all students in the class If yes: NO INSULIN CARB COVERAGE ONLY OTHER ____________________ If you do not want your child included in group snacks or would like to be notified prior to any snacks given, please specify. Also comment if you prefer to provide snacks from home, any restrictions to snacks based on individual glucose levels, or other related comment/treatment/limitation:

SIGNATURES/ADDITIONAL COMMENT

Other Comment/Treatment/Limitation:

I grant permission for the school nurse to carry out the diabetes care as outlined above and in connection to the physician ordered diabetes management and school policy, and to provide my child with nutritional and diabetes related education and review. It is my parent responsibility to report any changes in my child's care, and keep adequate supplies at school. I also consent to the release of information contained in this plan to all school staff members who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse to contact my child's physician/health care provider.

Parent Signature: ______________________________ Date: ____________

School Nurse Signature: ______________________________ Date: ____________

Addendum for School Related Field Trips:

Evening Care (Please complete)

Any difference in coverage for Dinner from Lunch: ____

Evening Snack (time/limitation): ____

Evening Blood Glucose Check (time/treatment/limitation): ____

____

Evening Insulin Routine:

Type of Insulin: ______________________________

Dose of Insulin: ______________________________

Time of Insulin: ______________________________

Night Routine:

Blood Glucose Level Check (time and parameters): ____

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____

Any other direction/comment/concern regarding off school hour care: ______________________________

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Parent Signature: ____ Date: ______________

Nurse Signature: ____ Date: ______________