DIABETES MANAGEMENT PLAN
Avon Lake City Schools

Student's Name	Date of Birth	Building/Grade	School year
Address			

Instructions: Parent/Guardian and Provider: Please compete this Diabetes Management Plan and any medication orders and return them to the school. Please notify the school with any changes.

Blood glucose monitoring: Student can perform own blood glucose checks (with/without supervision)
Times to check blood glucose: _____ with symptoms of low/high blood glucose
_____ with lunch (see snacks below)
_____ before dismissal
_____ other:_____
_____ student may carry own meter and supplies with them
Target range _____ to _____ mg/d

Hypoglycemia Treatment: (low blood sugar <_____)
Shaky, sweaty, changes in Behavior
_____ 2-4 glucose tabs or
_____ 4 oz. juice or 6 oz. soda (not diet or low cal)
_____ Glucose gel (place between cheek & gum in mouth) ½ - 1 tube
_____ Follow treatment with 15 gm snack or meal within 1 hour

Severe Hypoglycemia Treatment:
(severe low blood sugar, with unconsciousness, seizures)
_____give glucagon (subq in arm or thigh)
_____ 0.5mg (under 44 #) _____ 1.0 mg (over 44#)- Check dose
_____ **CALL 911**; notify parent/guardian

Hyperglycemia Treatment
(high blood sugar > _____
increased thirst/dry mouth
frequent urination)
_____ provide water & flexible bathroom privileges
_____ test urine for ketones if blood glucose is 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 not taking insulin at school
_____ Student takes insulin at school

_____ insulin injections _____ Humalog _____ Novolog _____other: _____
_____ Insulin pump /type _____ meal coverage _____ units/per _____ gm carbohydrates
_____ Insulin w/ lunch _____ correction scale: If BG > _____ add _____ units
_____ Insulin w/ snacks If BG > _____ add _____ units
If BG > _____ add _____ units
If BG> _____ add _____ units
_____ student may give own injections If BG> _____ add _____ units
_____ student may give own pump boluses
_____ student may determine correct dose of insulin
_____ student needs assistance with insulin administration ***For parties/special occasions, contact parent**
_____ student may carry insulin with them

Snacks: _____Please allow a _____ gram snack at _____ am _____ with coverage _____ w/o coverage
_____Please allow a _____ gram snack at _____ pm _____ with coverage _____ w/o coverage
_____Please allow a 15 gram snack prior to gym class if blood glucose < 100 or <_____

Return form to school office. Thank you

PARENT/GUARDIAN TO PROVIDE SCHOOL WITH CHANGES IN DIABETES MANAGEMENT Parent may be contacted for dose confirmation or with blood sugar < 70 or > 400		
Parent signature:	**Emergency Phone:**	**Date:**
Parent name (print)	**Additional Phone #:**	
Provider name (print)	**Address**	**Phone**
Provider Signature:	**Date**	**Fax**

I, (parent/guardian :) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school :) _____ to perform and carry out the diabetes care tasks as outlined in (student:) _____ 's Diabetes Management Plan.
I also consent to the release of the information contained in this Diabetes Management Plan to all school staff members and other adults 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 or another qualified health care professional to contact my child's physician/health care provider.
Acknowledged and received by:
Student's Parent/Guardian _____ Date: _____
Student's Parent/Guardian _____ Date: _____
School Nurse/ Other Qualified Health Care Personnel _____ Date: _____

Return form to school office. Thank you