



<b>Student</b>		<b>Date of Birth</b>	<input type="checkbox"/> <b>Type I</b>	<input type="checkbox"/> <b>insulin shots</b>	<input type="checkbox"/> <b>insulin pump</b>
			<input type="checkbox"/> <b>Type II</b>	<input type="checkbox"/> <b>no meds</b>	<input type="checkbox"/> <b>oral meds</b>
School	Year -		Parent/Guardian		
Teacher/1 <sup>st</sup> Hour					
Grade	Valid for current school year only		Cell Phone	Alt Phone	

Insulin/Medication Supervision:  needs supervision with insulin  student can perform without supervision  requires staff to perform  
 Meals at School:  Breakfast  Lunch  Snack  
 Blood Glucose Monitoring:  needs supervision to test glucose  student can perform without supervision  requires staff to perform  
 Time to Check Glucose:  mid-morning  before lunch  before PE  before getting on afternoon bus  
 signs/symptoms of hypo/hyperglycemia  as needed  
 Supplies:  with student  in office  in classroom # \_\_\_\_\_

Target Blood Glucose:  70-130  70-180  Other \_\_\_\_\_ Check Ketones when above \_\_\_\_\_ or vomiting

<p><b><u>LOW BLOOD SUGAR</u></b></p> <p>Signs: shaky, nervous, sweaty, pale, confusion, dizzy, irritable</p> <p>_____</p> <p>Do This: check glucose        give snack (15 gms carb)        wait 15 minutes        repeat snack if glucose not above _____</p> <p>Do not leave student alone        If sending to office/nurse, provide escort</p>	<p><b><u>HIGH BLOOD SUGAR</u></b></p> <p>Signs: stomach ache, thirsty, irritable, confused, frequent bathroom requests</p> <p>_____</p> <p>Do This: check glucose        give insulin per sliding scale        give water        wait at least one hour        recheck glucose        call parent/legal guardian before repeating insulin dose        check ketones, send home if mod or large</p> <p>Do not leave student alone        If sending to office/nurse, provide escort</p>	<p><b><u>EXERCISE</u></b></p> <p>If glucose <u>below</u> _____ <u>before activity</u></p> <p><input type="checkbox"/> give 15 gm carbohydrate snack for low activity level  <input type="checkbox"/> give 25 gm carbohydrate snack for high activity level  <input type="checkbox"/> give _____ carbohydrate snack for _____ activity  <input type="checkbox"/> glucose must be above _____ before activity</p> <p>If glucose <u>above</u> _____</p> <p>Give insulin, give water  <input type="checkbox"/> student may walk only  <input type="checkbox"/> student should not exercise</p> <p>If PE/recess is just after lunch, glucose check not needed.        Athletes should always check glucose before, during, and after sports</p>
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<p><b><u>Carbohydrate Counting</u></b></p> <p><input type="checkbox"/> no carb counting</p> <p>Meals  <input type="checkbox"/> _____ units per _____ gm/carb</p> <p>Snacks  <input type="checkbox"/> _____ units per _____ gm/carb</p> <p><input type="checkbox"/> Set Doses Bkf _____ units        Lunch _____ units        Snacks _____ units</p> <p>Do not give insulin more than every _____ hours.</p> <p>*Attach scale/dosing as prescribed.</p>	<p><b><u>Sliding Scale Coverage</u></b></p> <p>_____ give _____ units        _____ give _____ units        _____ give _____ units        _____ give _____ units</p> <p>Do not give more than every _____ hours</p> <p>*Attach scale/dosing as prescribed.</p>	<p><b><u>Type of Insulin</u></b></p> <p><input type="checkbox"/> Humalog**  <input type="checkbox"/> Novolog**  <input type="checkbox"/> Other _____</p> <p><b><u>Oral Medications (Home)</u></b></p> <p><input type="checkbox"/> Glucophage / Metformin  <input type="checkbox"/> Other _____</p> <p><b><u>Emergency Glucose</u></b></p> <p><input type="checkbox"/> Tablets**  <input type="checkbox"/> Glucagon* (**)  <input type="checkbox"/> Other _____</p> <p>*Dr. Order Required</p>	<p><b><u>Insulin PUMP(all calculations for dose of insulin done by pump)</u></b></p> <p>Target Range _____</p> <p>Insulin Sensitivity Factor _____</p> <p><u>Current BS – Target BS</u> = # units        Insulin Sensitivity Factor</p> <p><b><u>Continuous Glucose Monitoring</u></b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>*Check blood sugar with glucose meter before taking action</p>
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**Provider Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Provider Printed Name** \_\_\_\_\_

I give permission to the school nurse or other trained diabetes personnel of Carman-Ainsworth schools to perform and carry out the diabetes care tasks as outlined in the Diabetes Medical Management Plan above. I also consent to the release of the information contained in the plan to all school staff members and other adults who have responsibility for my child and 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 above regarding this plan and medications.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Printed Name** \_\_\_\_\_