DIABETES MANAGEMENT PLAN

Date:______________

Child's Name:____________________________Birthdate:_____________Age:_____________

Classroom:______________________________

DIABETIC MANAGEMENT:
(To be completed by parent with physician's assistance):

Condition: Diabetes type I ___ Diabetes type II ___ Child's age when diagnosed ___

List all current medications:

Name:	Dosage:	Exp. Date:
Name:	Dosage:	Exp. Date:
Name:	Dosage:	Exp. Date:

What time should we test blood glucose levels at school: ___________________________________

What is a satisfactory blood glucose range where no action is needed? ________________________

We will text the results to the parent and wait for instructions.

Parents name:	Parents phone #:

Does your child have any diet restrictions? (ex. Should the child eat only food from home? Can they have a food brought in by another student to share with the class?) Be specific:

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If blood glucose levels are outside of normal range, and we can't reach the parents, what should we do?

For Hypoglycemia (less than normal range):

- What symptoms should we watch for if your child is hypoglycemic:

  ____

  ____

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- Intervention

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For Hyperglycemia (greater than normal range):

- What symptoms should we watch for if your child is hyperglycemic:

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- Intervention

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List other health concerns (if any):____

Is the child able to check blood glucose levels themselves?____________________________________
Is the child able to administer insulin themselves? _______________________________________
Does the child have an insulin pump? ____
Does the child have a continuous glucose monitor? ____

Dr. Name:	**Dr. Phone #:**
Dr. Signature:	**Date:**

Physician comments:____
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Parent/Guardian signature:___________________________________Date:____________________

Received/Reviewed by:_______________________________________Date:____________________
School staff