



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.

<u>Parents name:</u>	<u>Parents phone #:</u>

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:

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:

- Intervention

For Hyperglycemia (greater than normal range):

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

- Intervention

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: _____

Parent/Guardian signature: _____ **Date:** _____

Received/Reviewed by: _____ **Date:** _____

School staff