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:

_____

_____

_____

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