Rowan-Salisbury
SCHOOL SYSTEM
Extraordinary Education Every Day

Diabetes Management Plan – Insulin Injection

Student:	Birthdate:
Teacher/Grade:	Transportation ☐Bus # _____ ☐ Car rider

Blood Glucose(BG) – Monitoring

Test Blood Glucose: ☐ Before meal ☐ Before Exercise ☐ Before snack ☐ Before bus/dismissal

☐ If symptoms of low or high blood glucose ☐ Other ________________

Hypoglycemia (Low blood glucose): Student should be sent to office accompanied by an adult if symptomatic or if blood glucose is less than 80mg/dL.

- This students most common complaint(s) when blood glucose is low or dropping is:
  ____
- Test blood glucose if complaints – if blood glucose meter is not available, treat symptoms.
- For blood glucose less than __________mg/dL: Treat with 15 gram carbohydrate snack (juice glucose tab, etc) and recheck every 10-15minutes and retreat if necessary until above __________mg/dL. Then treat with protein snack or lunch and notify parent.
- Carbohydrates that were used to bring blood glucose up to within target range should NOT be covered with insulin.

- **If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give: Glucagon ________mg(s) IM or SQ and call 911, position student on side because may vomit then notify parent/guardian. When regains consciousness follow with fast glucose.**

Hyperglycemia (High blood glucose):

- This student's most common complaint(s) when blood glucose is high is: ______________________________
- If elevated blood glucose encourage water or sugar-free fluids. Allow unrestricted bathroom privileges.
- **Check urine ketones if blood glucose is over ________ or with symptoms of nausea/vomiting**. If ketostix is not available continue with treatment steps below. **Recheck blood glucose in: ☐ one hour ☐ two hours.**
- If ketones present, call parent, provide water and student should NOT exercise.
- If student has moderate to large ketones and/or symptoms of nausea and vomiting call parent/guardian to pick up in order to be treated and monitored more closely and encourage calling to doctor.
- For blood glucose greater than ________mg/dL AND at least 2 hours since last insulin dose, give correction dose of insulin (see correction dose page 2).
- No exercise if blood glucose is higher than _______ mg/dL or if urine/blood ketones are moderate to large.

(continued on back of sheet)

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Student Name: ______________________ **Date of Birth:** ____________________

Insulin Therapy: Meals

Bolus for carbohydrates should occur immediately: ☐ Before meal ☐ After meal

Correction dose: should be at least 2 hours since last insulin dose.

Breakfast:	Carbohydrate limit for meal: __________ grams	☐ no limit	
	Give ______ units of insulin per _______ grams of carbohydrates		
Lunch:	Carbohydrate limit for meal: __________ grams	☐ no limit	
	Give ______ units of insulin per _______ grams of carbohydrates		
Snack:	Student to have scheduled snack: ☐ yes ☐ no	If yes, when:	
☐ If snack greater than _________ grams of carbohydrates cover with insulin			
	Give ______ units of insulin per _______ grams of carbohydrates		
☐ No insulin coverage for snacks.			

Insulin administration

- Type of insulin: ________________ Administered via: ☐Syringe ☐Insulin Pen
- Correction Scale: Blood glucose correction may be used every _______ hours.
  Blood Glucose Range ______________mg/dL Administer ________ units
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  Blood Glucose Range ______________mg/dL Administer ________ units
- Parent/Guardian authorized to increase or decrease correction scale within the following range: +/-2 units of insulin.
  ☐ Yes ☐ No

Student's Ability to Self-Manage Diabetes

Totally independent in all aspects of care: ☐ Yes ☐ No **If you answered yes, skip to signatures**

Skill	Yes	No	Skill	Yes	No
Needs assistance testing blood glucose			Injects insulin with trained staff supervision		
Needs verification of blood glucose by staff			Injections to be done by trained staff		
Needs assistance counting carbohydrates			Injects insulin independently		
Monitors own snacks and meals			Tests and interprets urine ketones		

Signatures:

1. **Physician Authorization for Medication Administration and Specialized Health Care procedures:**

   Physician's signature: ______________________________ **Date:** ________________

   Office telephone #: ________________ ***Physician's Address or stamp:***

   Fax #: ________________

2. **Student contract for Self-Administered Medication**
   - I will be responsible for my own diabetic supplies at school. Where are the diabetic supplies kept during the school day? ____
   - I agree to use my diabetic supplies/medication in a responsible manner, in accordance with my doctor's orders.
   - I will notify the school nurse or main office if I am having difficulty with my diabetes.
   - I will not allow any other person to use my diabetic supplies/medication.

   Student's signature: ________________________ **Date:** ____________

   Nurse's signature: ________________________ **Date:** ____________

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