

Diabetes Management Plan

Important Information:

Name: _____

Date: _____

Doctor Name: _____

Doctor Phone: _____

Emergency Contact: _____

Emergency Phone: _____

Insulin Therapy

Student Self-Care Insulin Administration Skills:

- | | | |
|---|-----|----|
| • Independently calculates and gives own injections | YES | NO |
| • May calculate/give own injections with supervision | YES | NO |
| • Requires school nurse or trained diabetes personnel to calculate/ give injections | YES | NO |

Additional Information for Student with Insulin Pump:

Brand/Model of Pump: _____

Type of Infusion Set: _____

For blood glucose greater than _____mg/dL that has not decreased within _____hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.

When to Give Insulin:

Lunch

Carbohydrate coverage only

Carbohydrate coverage plus correction dose when blood glucose is greater than

_____Mg/dL and _____ hours since last insulin dose.

Other: _____

