

**Jackson Local Schools**  
**DIABETES MANAGEMENT PLAN**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ School Year: \_\_\_\_\_

**Blood Glucose Monitoring:**  Blood Glucose Meter  CGM (Continuous Glucose Monitor)  
 Student can perform own blood glucose checks (with / without supervision)  
 Call parent if blood glucose **less than** \_\_\_\_\_ or **greater than** \_\_\_\_\_

**Testing Times:**  With symptoms of hypoglycemia  With symptoms of hyperglycemia  
 Before lunch \_\_\_\_\_ (time)  Before / after exercise  
 Other \_\_\_\_\_  Student may carry own meter and supplies

**Hypoglycemia Treatment:** For blood sugar < **70** (or specific range) \_\_\_\_\_  
 2 – 4 glucose tablets  4 oz. juice  
 Glucose gel (1/2 tube)  Other \_\_\_\_\_  
 If no meal or snack scheduled within the hour, then give 15 gram snack  
 Recheck blood glucose after 15 minutes for hypoglycemia  
 If blood glucose level has not risen above \_\_\_\_\_, treat with \_\_\_\_\_

**Hyperglycemia Treatment:** For blood sugar > **250** (or specific range) \_\_\_\_\_  
 Provide water and access to the bathroom  Insulin (see below)  
 Other \_\_\_\_\_

**Insulin Orders:**  Student is **NOT** taking insulin at school  
 Student takes insulin at school (Novalog/Humalog)  
Route:  SQ insulin  Insulin via pump  
Meal coverage: \_\_\_\_\_ unit(s)/ \_\_\_\_\_ grams of carbohydrates  
Correction scale: \_\_\_\_\_ unit(s) for every \_\_\_\_\_ points over \_\_\_\_\_  
 Insulin with lunch/snacks  
 Parents authorized to adjust insulin dose  
 Student may give own SQ injections (with / without supervision)  
 Student using an insulin pump may give own boluses  
 Give insulin according to above sliding scale for elevated blood glucose at meals only  
 Student may determine correct dose of insulin  
 Insulin dosing based on CGM (continuous glucose monitor)  
 School to administer insulin  
 Student may carry insulin and testing supplies with them

**Glucagon Orders:**  1mg of Glucagon for instances of severe hypoglycemia  
 Student to keep glucagon kit in school clinic  
 Student to carry glucagon kit on person

**Snacks:**  Please allow a \_\_\_\_\_ gram snack at \_\_\_\_\_ AM  
 Please allow a \_\_\_\_\_ gram snack at \_\_\_\_\_ PM  
 Please allow a 15 gram snack prior to gym class if blood glucose is < **100**

**Additional Instructions:** \_\_\_\_\_  
\_\_\_\_\_

*I give permission to the school nurse and other designated staff members of Jackson Local Schools to perform the health management tasks as outlined by this Individualized Health Plan. I also consent to the release of the information contained in this plan to all staff members who have custodial care of my child and may need to know this information to maintain my child's health and safety while at school and extracurricular activities.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature/Phone: \_\_\_\_\_ Date: \_\_\_\_\_