15181 St. Rt. 58 South
Oberlin, OH 44074
Nurse-440-774-1051 ext. 2228
Fax-440-774-6421

# Diabetes Management Plan & Medical Orders

**School Year _____**

| Student's Name | Date of Birth | Home School/Program | Grade |
|---|---|---|---|
| | | | |

**Instructions: Parent/Guardian and Prescriber: Please complete these orders and the Action Plan for Diabetes and return them to the School Nurse. Please contact the School Nurse with any changes in orders.**

**Blood Glucose Monitoring:** Student can perform own blood glucose checks (with supervision/without supervision.)

Times to check blood glucose: ____ with symptoms of hypoglycemia (shaky, sweaty, confused)
____ with symptoms of hyperglycemia (thirsty, frequent urination)
____ before lunch
____ other _____
____ student may carry own meter and supplies with them.

Check Supplies to be kept at School: Insulin, syringes, meter supplies, ketone strips, carb/snacks and glucagon.

**Hypoglycemia Treatment:** (low blood sugar)
2 – 4 glucose tablets or
4 oz of juice or
Glucose gel (using finger place between check & gum in mouth) – ½ tube
If no meal or snack within the next hour, then give a 15 gram snack. Example:_____

**Severe Hypoglycemia Treatment:** (ie.: loss of consciousness, seizure)
____ glucose gel or cake decorating gel (1/2 tube between cheek & gum)
____ glucagon (give 0.5 mg/1 mg. SQ in the arm or thigh)
____ call 911

**Hyperglycemia Treatment:** (high blood sugar)
____ Provide water & access to bathroom
____ test urine ketones if blood glucose is greater than ____, call parent if moderate or large
____ see below for insulin instructions if applicable

**Insulin:** ____Student not taking insulin at school
____ Student takes insulin at school

| | | |
|---|---|---|
| ____ SC insulin | ____Humalog | ____meal coverage: ____ units per ____ grams of carbs. |
| ____ Insulin via insulin pump | ____ Novolog | ____ correction scale: ____ unit per ____ over ____ |
| ____ Insulin with lunch | ____ Humulin R | ____ sliding scale (confirm with parent) |
| ____ Insulin with snacks | ____ other:_____ | |

____ Student may give own SC injections (with supervision/without supervision)
____ Student using an insulin pump may give own boluses
____ Give ____ units of Humalog/Novolog/Humulin R – SO if glucose is > ____
____ Give insulin according to scale for elevated blood glucose
____ Student may determine correct dose of insulin
____ Student to administer insulin
____ Student may carry insulin with them

**Oral Meds:** ____500 mg/ ____ 850 mg/ ____ 1000 mg Metformin with ____ breakfast/ ____ lunch
Other: _____

**Snacks:** ____please allow a ____ gram snack at ____ am Example: _____

Other: _____
Parent/Guardian to provide current insulin doses as doses may change during year.
**Please contact parent if dose confirmation is needed or if blood sugar is less than 70 or over 400**.

| | | | |
|---|---|---|---|
| Parent Signature: | Date: | Phone: | |
| Provider Office Name: | Address: | Fax: | Phone: |
| Providers name (please print) | Providers signature | Date: | |

**Please return this form to the High School Office.**

Revised November 2011 MKW