DIABETES MEDICAL	MANAGEMENT PLAN (Sch	ool Year			
Student's Name:	Date of Birth:	Diabetes 🗆 Type 1 : [	□ Type 2 Date	of Diagnosis :	
School Name:			Plan Effectiv	e Date(s):	
		T INFORMATION			
Parent/Guardian #1:					
Parent/Guardian #2:	Phone Numbers I	Home Wo	rk	Cell/Pager	-
Diabetes Healthcare Provider					
Other Emergency Contact		Phone Numbers home			_
EMERGENCY NOTIFICATION: Notify parent         a.       Loss of consciousness or seizure (conv         b.       Blood sugars in excess of         c.       Positive urine ketones.         d.       Abdominal pain, nausea/vomiting, diagonal	ulsion) immediately after Glucago mg/dl	n given and 911 called.		rncare Provider listed above)	
MEALS/SNACKS: Student can: D Determin	e correct portions and number of car	bohydrate serving D C	alculate carbohy	drate grams accurately	
Time/Location Foo	od Content and Amount	Time/Loc	cation	Food Content and Amount	
	🗆 N				-
If outside food for party or food sampling					
BLOOD GLUCOSE MONITORING AT SCHO	JUL: 🗆 Yes 🗀 No	Type of Mete	r:		-
<ul> <li>Midmorning: be</li> <li>Before breakfas</li> </ul>		□ After PE/Activity Time □ Mid-afternoon			
OPTIONAL: Target Range for blood glucose INSULIN INJECTIONS DURING SCHOOL: If yes, can student: Determine correct do Give own injection? Insulin Delivery:  Syringe/Vial Pen Standard daily insulin <u>at school</u> : Yes	Clinic/Health Room Clinic/Health Room Clinic/Health Room Clinic Health	As needed for signs/sy Other(Complet    (Complet     difference of the set of the	e insulin neede No	Healthcare Provider). d at school	<b>)</b> ")
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