



DIABETES MANAGEMENT PLAN & MEDICAL ORDERS

School Year _____

To be Returned to the School Nurse

Table with 4 columns: 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...
Hypoglycemia Treatment: 2-4 glucose tablets or 4 oz of juice...
Severe Hypoglycemia Treatment: glucose gel or cake decorating gel...
Hyperglycemia Treatment: Provide water & access to bathroom...
Insulin: Student not taking insulin at school...
Oral Meds: 500 mg/ 850 mg/ 1000 mg Metformin...
Snacks: please allow a gram snack at am...
Please contact parent/guardian if dose confirmation is needed or if blood sugar is less than 70 or over 400.

Table with 4 rows: Parent/Guardian Signature, Date, Phone; Provider Office Name, Address, Fax, Phone; Providers name, Providers signature, Date