Allegheny Valley School District
School Health Services
Diabetes Medical Management Plan

Student Name:_______________________________ **DOB:**_______ **GRADE:**_____

Age of Diabetes Diagnosis: ______________ **Diabetes Type:** ____ Type 1 ____ Type 2

Please complete the following information along with your child's diabetic healthcare provider to assistant the school nurse in developing an individualized health plan for your child. If you would like to discuss the plan, please call the school nurse.

Contact Information

#1 Parent/Guardian ____

Phone: (h) __________________ **(w)** ___________________ **(c)** _________________

#2 Parent/Guardian ____

Phone: (h) __________________ **(w)** ___________________ **(c)** _________________

Physician/Healthcare Provider : .____

Phone:____________________________ **address:** ______________________________

Other Emergency Contacts:

1. ____ ________________________
   Name relationship
   ____
   Phone -

2. ____ ________________________
   Name relationship
   ____
   Phone -

Diabetes Management Plan for: ____
Student Name

Target range for blood glucose is: ____ 70-150
____ 70-180
____ other (range) __________

Hypoglycemia (Low Blood Sugar)
Usual symptoms of hypoglycemia: ____

____

Treatment for hypoglycemia: ____

____

Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow.

Route:__________ Dosage:__________ site for glucagon injection:____________________

If glucagon is required, administer it promptly, then call 911 and parent/guardian.

Hyperglycemia (High Blood Sugar)
Usual symptoms of hyperglycemia:____

____

Treatment of hyperglycemia: ____

____

____

Urine should be checked for ketones when blood glucose levels are above: _________ mg/dl
Treatment for ketones: ____

Please also provide written documentation from the student's physician regarding medications to be given during the school day. The district Medication Administration form should be used. Information regarding insulin pump management (if applicable) should also be included for the school nurse.

Required Signatures:

This Diabetes Medical Management Plan has been approved by:

____ __________
Student's Physician/Health Care Provider Signature **Date**

____ __________
Parent/Guardian Signature **Date**