## Blood glucose monitoring

Student can perform own blood glucose checks (with/without supervision).

- Times to check blood glucose:
  - _____ with symptoms of low/high blood glucose
  - _____ with lunch (see snacks below)
  - _____ before dismissal
  - _____ other

- Target range ______ mg/d

### Hypoglycemia Treatment:

- 2-4 glucose tablets or
- (low blood sugar <______)
- 4 oz juice or 6 oz soda (not diet or low cal)
- shaky, sweaty, change in behavior
- Glucose gel - (place between cheek & gum in mouth) - 1/2-1 tube
- Follow treatment with 15 gm snack or meal within 1 hour

### Severe Hypoglycemia Treatment:

- _____ give glucagon (subq in arm or thigh)
- (severe low blood sugar, with unconsciousness, seizures)
- _____ 0.5mg (under 44#) _____ 1.0mg (over 44#)
- _____ call 911; notify parent/guardian

### Hyperglycemia Treatment:

- _____ provide water & flexible bathroom privileges
- (high blood sugar >______)
- _____ test urine for ketones if blood glucose greater than_______
- _____ call parent if ketones are moderate or large
- _____ frequent urination
- _____ see below for insulin instructions if applicable
- _____ check pump (if applicable) for proper functioning

### Insulin:

- _____ Student not taking insulin at school
- _____ Student takes insulin at school
- _____ insulin injections
- _____ Humalog
- _____ Novolog
- _____ other
- _____ Insulin/pump
- _____ meal coverage: _____ units/per _____ gm carbohydrates
- _____ Insulin w/lunch
- _____ correction scale: If BS >______ add _____ units
- _____ Insulin w/snacks
- _____ if BS >______ add _____ units
- _____ student may give own injections
- _____ if BS >______ add _____ units
- _____ student may give own pump boluses
- _____ if BS >______ add _____ units
- _____ student may determine correct dose of insulin
- _____ student needs assistance with insulin administration

*For parties/special occasions, contact parent*

### Snacks:

- Please allow a _____ gram snack at _____ am _____ with coverage _____ w/o coverage
- Please allow a _____ gram snack at _____ am _____ with coverage _____ w/o coverage
- Please allow a 15 gm snack prior to gym class if blood glucose <100

### PARENT/GUARDIAN TO PROVIDE SCHOOL WITH CHANGES IN DIABETES MANAGEMENT

Parent will be contacted for dose confirmation or with blood sugar <70 or >400.

- Parent signature:_________________________
- Emergency Phone:________________________
- Date__________________
- Provider name(print)_________________________
- Address____________________________________
- Phone__________________________
- Provider signature_____________________________________
- Date__________________
- Fax__________________

Return form to school office. Thank you.