KAMEHAMEHA SCHOOLS®
MĀLAMA OLA • HEALTH SERVICES DEPARTMENT

DIABETES MANAGEMENT PLAN

Campus: _____ School Year: _____ Grade: _____ Date: _____

Student Name: _____ Student ID: _____ Date of Birth: _____

Medication(s): _____

Allergies: _____

Emergency Contacts:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian/Alternate Name: _____ Phone: _____

Healthcare Provider Name: _____ Phone: _____

1. Blood Glucose Testing

☐ Before lunch/meals
☐ For suspected hypoglycemia
☐ At student's discretion
☐ No blood glucose testing at school
Expected blood glucose range at school: _____

2. Hypoglycemia – Refer to EAP

☐ Assistance for all lows
☐ OK to use glucose gel inside cheek if conscious
☐ Glucagon IM (must be administered by RN or other trained provider)
  ☐ 0.5 mg wt ≤ 44 lbs
  ☐ 1.0 mg wt ≥ 45 lbs

3. Hyperglycemia – Refer to EAP

If blood glucose is > _____ mg/dL:
☐ Check ketones if blood glucose is high > 2 hours post carbohydrate consumption
  ☐ Urine ☐ Blood
If ketones are _____ or greater, then:
_____
☐ Other: _____

4. Meals/Snacks

☐ Adult supervision to assure student eating
☐ AM snack time: _____
☐ PM snack time: _____
☐ Other: _____
☐ Extra food allowed:
  ☐ Vigorous exercise
  ☐ Bus rides over 30 minutes

5. Insulin Orders

☐ No Insulin orders: Student can self-manage
☐ Insulin orders: Provider to complete details below if student is unable to self-manage.

Administration time:

☐ Before breakfast ☐ Before AM snack
☐ Before lunch ☐ Before PM snack
☐ Other: _____

Insulin administration via:

Insulin type: _____
☐ Syringe and vial ☐ Insulin pen
☐ Insulin pump ☐ Other: _____

Dosage*:

☐ Standard lunch time dose: _____ units
☐ Sliding scale dosing:
  From _____ to _____ = _____ units
  From _____ to _____ = _____ units
  From _____ to _____ = _____ units
  From _____ to _____ = _____ units
  From _____ to _____ = _____ units
  From _____ to _____ = _____ units
☐ As per pump
☐ 1 unit for _____ carbs
  Insulin dosage is based on carb count. Carb count and insulin calculation shall be the responsibility of parents/guardians and students.

***If insulin dosage adjustment is needed, parent/guardian will instruct student of change and a new Diabetes Management Plan should be submitted.**

Provider Name: _____ Signature: _____ Date: _____