Diabetes Management Sheet

Name ______________________ Teacher ______________________
Date of birth ______________________ Grade ______________________
Age at diagnosis ______________________

Parent or Guardian ______________________ Phone ______________________
Parent of Guardian ______________________ Phone ______________________
Physician ______________________ Phone ______________________
Physician ______________________ Phone ______________________
Other contact ______________________ Phone ______________________

Treatment

Name of medication	Dose	Time	Notes
insulin			

Snack

Item	Amount	Time	Notes

Monitoring

	Time
Check blood sugar at	
Check blood sugar at	
Check blood sugar at	

If blood sugar below ______________________ give the following

- ☐ glucose tabs
- ☐ juice
- ☐ other

If blood sugar above ______________________ give the following

- ☐ water
- ☐ other

If blood sugar above ______________________ check ketones before exercising

The emergency glucagon kit is kept in the nurse’s office. Please consult with the nurse about its specific location and administration.

I give the school nurse permission to communicate with child’s doctor if necessary.

Parent/Guardian Signature ______________________ Date ______________________

Parent/Guardian Signature ______________________ Date ______________________