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 _____