# High Trails Outdoor Science School

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RUNNING PROGRAM IN THE
SAN BERNARDINO NATIONAL FOREST
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LEARNING HOW WE CAN ALL FIT TOGETHER ON ONE HEALTHY PLANET


# Diabetes Management Plan

## CONTACT AND HISTORY

| | |
|---|---|
| **This Plan Is Due At Least One (1) Week Before Attendance.** | School Name: |
| Student's Name: | Date of Birth: |
| Parent/Guardian Name: | Contact Phone #: |
| Date of Diabetes Diagnosis: | Diabetes Condition: ☐ Type 1 ☐ Type 2 |
| Hypoglycemia history and symptoms: | Hyperglycemia history and symptoms: |
| Normal Blood Glucose Range: _____ to _____ mg/dl | Notify parents/guardian in the following situations: |

## BLOOD GLUCOSE MONITORING

| | | |
|---|---|---|
| Can student perform own blood glucose checks? ☐ Yes ☐ No | Exceptions: | Type of Blood Glucose Meter: |

## INSULIN DOSES

| | |
|---|---|
| Can student give own injections? ☐ Yes ☐ No | Can student determine correct amount of insulin? ☐ Yes ☐ No |
| Contact parent before administering correction dose? ☐ Yes ☐ No | Can student draw correct dose of insulin? ☐ Yes ☐ No |

☐ **Regular Insulin Dose** **OR** ☐ **Flexible Dose** of ___units per ___ grams carbohydrates

| *Test Schedule* | *No* | *Yes* | *Insulin Dose / Type* | *Insulin Dose / Type* | **Correction Insulin Dose** *Units* | *Blood Sugar Level* |
|---|---|---|---|---|---|---|
| Overnight: 2am | | | ____ units of _____ | ____ units of _____ | _____ | ____ to _____ mg/dl |
| Early: 6am | | | ____ units of _____ | ____ units of _____ | _____ | ____ to _____ mg/dl |
| Breakfast: 8am | | | ____ units of _____ | ____ units of _____ | _____ | ____ to _____ mg/dl |
| Lunch: 1pm | | | ____ units of _____ | ____ units of _____ | _____ | ____ to _____ mg/dl |
| Dinner: 6pm | | | ____ units of _____ | ____ units of _____ | _____ | ____ to _____ mg/dl |
| Bedtime: 9pm | | | ____ units of _____ | ____ units of _____ | _____ | ____ to _____ mg/dl |
| Other: | | | ____ units of _____ | ____ units of _____ | OK to add **correction** to regular insulin dose? ☐ Yes ☐ No | |
| Other: | | | ____ units of _____ | ____ units of _____ | | |

**Notes on Insulin Doses:**

☐ **Insulin Pump:** student must be competent in complete pump management and maintenance.

## MEALS AND SNACKS

| | | | |
|---|---|---|---|
| Is student independent in carb calculations and management? ☐ Yes ☐ No | Does student carry own snacks on person? ☐ Yes ☐ No | Is student permitted to eat snacks at own discretion? ☐ Yes ☐ No | |
| Gram Carb Count: ☐ Breakfast: ____g | ☐ Lunch: ____g | ☐ Dinner: ____g | ☐ _____: ____g |
| ☐ AM Snack: ____g | ☐ PM Snack: ____g | ☐ Bedtime Snack: ____g | ☐ _____: ____g |

**Notes on Meals and Snacks:**

## SUPPLIES AND EQUIPMENT PROVIDED BY STUDENT / PARENTS / GUARDIAN

| | | |
|---|---|---|
| ☐ Blood Glucose Meter, test strips, extra batteries | ☐ Urine Ketone Strips | ☐ |
| ☐ Fast acting source of glucose | ☐ Insulin pen, pen needles, cartridges | ☐ |
| ☐ Lancet device, lances, gloves, etc. | ☐ Insulin Pump and Supplies | ☐ |
| ☐ Snack containing carbs | ☐ Glucagon Emergency Kit | ☐ |

## DOCTOR SIGNATURE

| | | |
|---|---|---|
| My signature provides authorization for the above management plan, including administration of Glucagon and Insulin by trained diabetes personnel. I understand that all procedures will be implemented in accordance with state laws and regulations. | Doctor Name: | Signature: |
| | Phone Number: | Date: |

## PARENT / GUARDIAN SIGNATURE

| | | |
|---|---|---|
| Parent / Guardian Name: | Signature: | I, the parent/guardian of the above student, verify that all of the above information is complete, accurate and recent. I give permission to the High Trails medic and trained diabetes personnel to perform and carry out the diabetes care tasks as outlined in the above Diabetes Management Plan. |
| Phone Number: | Date: | |