DIABETES CARE GUIDE for _____ Based on DMMP for school year _____

Self-Care YES ☐ NO ☐ **Supervised ☐ Unsupervised ☐**		**SYMPTOM AWARE YES ☐ NO ☐**	**Out of Classroom Travel with**	**Symptoms Present** **Adult ☐ Peer ☐**	**At All Times** **Adult ☐ Peer ☐**
INSULIN		**Breakfast**	**am Snack**	**Lunch**	**pm Snack**
Time					
ROUTINE BLOOD GLUCOSE CHECKS		**Breakfast**	**Lunch**	**Gym/PE**	**Other**
Time					
ADDITIONAL BLOOD GLUCOSE CHECKS		When symptomatic			
EMERGENCY ACTION STEPS					
SEVERE LOW BLOOD GLUCOSE		**ACTION NEEDED**		**NEXT STEPS**	
• Unable to swallow Juice/Disoriented • Unconscious • Seizure		• Call 9-1-1 • Administer Glucagon • Call Parent		Send to hospital via ambulance	
CONDITION		**ACTION NEEDED**	**NEXT STEPS**	**NO IMPROVEMENT**	**FOLLOW UP**
MODERATE LOW BLOOD GLUCOSE					
CGM	**Finger Stick**				
<__		Treat with 30 grams rescue carbohydrates- Juice	Recheck with Finger stick in 15 minutes	• Treat based on current FS • Call Parent	• If > an hour from meal snack of complex carbohydrate and protein
	<___	Treat with 30 grams rescue carbohydrates- Juice	Recheck with Finger stick in 15 minutes	• Repeat **RULE OF 15** • Call Parent	• If > an hour from meal snack of complex carbohydrate/protein
MILD LOW BLOOD GLUCOSE					
___ - ___		Give 15 grams rescue carbohydrates – Juice **Rule of 15**	Recheck with Finger stick in 15 minutes	• Repeat **RULE OF 15** • Call Parent	• If > an hour from meal snack of complex carbohydrate and protein
	___ - ___ or ___ - ___ with Symptoms	Give 15 grams rescue carbohydrates – Juice **Rule of 15**	Recheck with Finger stick in 15 minutes	• Repeat **RULE OF 15** • Call Parent	• If > an hour from meal snack of complex carbohydrate and protein
___ – ___ ↓↓		Finger Stick			
___- ___before physical activity	<100	Give snack			
HIGH BLOOD GLUCOSE					
>300		Finger Stick if > 300 for > than 1 hour			
	>300		• Call parent	• Check for Ketones • Give 8-16 oz. water	

Rule of 15 = 15 grams Carbohydrates, wait 15 minutes, recheck Blood Glucose

The following staff members have received training to support the implementation of the DMMP for _____

NAME	ROLE	DATE OF LEVEL 2 TRAINING	DATE OF LEVEL 3 TRAINING	RETURN DEMONSTRATION OF SKILLS

Training Provided by RN, Physician, or PA:

Print Name	Signature	Initials	Date