Student Name:		DOB:	

A1c = _____.%

Basal (at home) Insulin: **Type:**_____.	_____. units	
Bolus Insulin: **Type:**_____.	Insulin to Carbohydrate ratio. Breakfast: ____. unit/ ____. grams Lunch: ____. unit/ ____. grams Dinner: ____. unit/ ____. grams Snack: ____. unit/ ____. grams Total Meal Carbs ÷ Insulin to Carbohydrate ratio = ____. units	**Correction Formula:** **Use when BS is > ____. mg/dL during the day.** Target Blood Sugar = _____. Sensitivity/Correction factor = _____. (Blood Sugar - Target) ÷ Sensitivity (_____. - _____.) ÷ _____. = _____. units Correction dose given every 3 hours.

Total insulin dose: ❑ Standard rounding ❑ Round Down ❑ 1/2 unit dosing	Carbohydrate ratio dose **+** Correction dose **=** Total insulin dose = _____. units

Meal Plan:	
Blood Sugar Checks:	❑ Before Meals ❑ Before Exercise (if BS below _____. or above _____. DO NOT exercise.) ❑ Before getting on the bus (where applicable) ❑ As needed for signs/symptoms of low or high blood sugar

Student's Self Care:

Totally independent management.	❑yes ❑ no	Injections to be done by trained staff.	❑yes ❑ no
Tests blood sugar independently.	❑yes ❑ no	Self treats mild hypoglycemia.	❑yes ❑ no
Tests and interprets urine/blood ketones.	❑yes ❑ no	Monitors own snacks and meals.	❑yes ❑ no
Needs verification of blood sugar by staff.	❑yes ❑ no	Independently counts carbohydrates.	❑yes ❑ no
Administers insulin independently.	❑yes ❑ no	Self injects with trained staff supervision.	❑yes ❑ no
Self injects with verification of dose.	❑yes ❑ no		

Physician Signature: _____ **Date:** _____

Reviewed by:

Parent Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____