

Meal Plan

- Breakfast time: _____ Lunch time: _____ Dinner time: _____
 Snack times: _____ Avoid snack if blood glucose greater than _____ mg/dl

Please list any specific diet requirements and/or restrictions:

Transportation

- Blood glucose monitoring is not required prior to boarding a vehicle
 Check blood glucose 15 minutes prior to boarding vehicle
 Allow participant to eat on vehicle if having symptoms of low blood glucose
 Other:

Does this participant require insulin? ____ Yes; ____ No. If yes, please complete the following:

Name of Insulin: _____

Insulin is administered via: Syringe/vial Insulin Pen Insulin Pump Other: _____

Insulin is given before meals at the following doses:

Routine Dose: _____

Per sliding scale as follows:

Blood Glucose _____ to _____, give _____ units

Blood Glucose _____ to _____, give _____ units

Blood Glucose _____ to _____, give _____ units

Blood Glucose _____ to _____, give _____ units

Calculated Insulin dose (add carbohydrate coverage and correction dose for total insulin dose):

Carbohydrate coverage: Insulin to carbohydrate ratio

Give _____ unit(s) of insulin per _____ grams carbohydrate

Correction:

Give _____ unit(s) of insulin per _____ mg/dl of glucose **above** _____ mg/dl

Subtract _____ unit(s) for every _____ mg/dl of glucose **below** _____ mg/dl

Insulin may be given after meals if: _____

Other times insulin may be given:

Snack Dose: _____; Calculated as above

Ketones If ketones are _____, give/add _____ unit(s)

Health Care Provider Assessment

Participant can self-perform the following procedures (Health Center staff and guardian must verify competency):

- Blood glucose monitoring Determine insulin dose Measure insulin
 Inject insulin Operate insulin pump independently
 Other:

Physician Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____

Legal Guardian Signature: _____ **Date:** _____