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| **❑** **Adjustable Bolus Insulin Therapy:** Apidra (glulisine), Novolog (aspart), Humalog (lispro), Fiasp (aspart), Admelog (lispro). Brands are interchangeable. |
| **When to give insulin:** | **INSULIN to CARBOHYDRATE****+** | **INSULIN to CARBOHYDRATE Only** | **Correction only**  |
| **Correction** |
| ***Breakfast*** | **❑** | **❑** | **❑** |
|  ***Lunch*** | **❑** | **❑** | **❑** |
| ***Snack AM*** | **❑** | **❑** | **❑** |
| ***Snack PM*** | **❑** | **❑** | **❑** |

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| **❑ INSULIN to CARBOHYDRATE Dose Calculation** |
|  ***Total Grams of Carbohydrate to Be Eaten***  ***“B” Insulin-to-Carbohydrate Ratio***X “**A” Units of Insulin** **=** \_\_\_\_\_ ***Units of Insulin***  |

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|  | ***“A” Units of Insulin***  | ***“B” Insulin-to-Carbohydrate Ratio*** |
| **❑ *Breakfast*** | \_\_\_\_\_\_\_\_\_ unit of insulin | Per \_\_\_\_\_\_ gm of carbohydrate |
| **❑ *Lunch*** | \_\_\_\_\_\_\_\_\_ unit of insulin | Per \_\_\_\_\_\_ gm of carbohydrate |
| **❑ *Snack AM*** | \_\_\_\_\_\_\_\_\_ unit of insulin | Per \_\_\_\_\_\_ gm of carbohydrate |
| **❑ *Snack PM*** | \_\_\_\_\_\_\_\_\_ unit of insulin | Per \_\_\_\_\_\_ gm of carbohydrate |

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| **❑ CORRECTION Dose Calculation (For Elevated blood sugar and > 3 hours since last insulin dose)** |  |
| ***Current Blood Glucose − “C” Target Blood Glucose*** =\_\_\_ ***Units*** ***of Insulin******“D” Correction Factor***X “**E” Units of insulin** |
| ***“C” Target Blood Glucose*** | ***“D” Correction Factor*** | ***“E” Units of insulin*** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **❑** 0.5 unit**❑** 1.0 unit |

**OR**

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| **❑ CORRECTION Dose Scale ((For Elevated blood sugar and > 3 hours since last insulin dose. Use instead of calculation above to determine insulin correction dose)** |
| **Blood Glucose** | **Insulin Dose** |
| \_\_\_\_\_ to \_\_\_\_\_ mg/dL | give \_\_\_\_\_ units |
| \_\_\_\_\_ to \_\_\_\_\_ mg/dL | give \_\_\_\_\_ units |
| \_\_\_\_\_ to \_\_\_\_\_ mg/dL | give \_\_\_\_\_ units |
| \_\_\_\_\_ to \_\_\_\_\_ mg/dL | give \_\_\_\_\_ units |

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| **❑** Fixed Insulin dose change: |
| **❑**Long-Acting Insulin dose change: |
| **❑**Other Changes: |

**This Diabetes Medical Management Plan has been approved by:**  |
| Parent / Guardian Name / Signature:  | Date: |
| School representative Name / Signature:  | Date: |
| Student’s Physician / Health Care Provider Name / Signature: | Date: |