STUDENT DIABETES ACTION PLAN

THE ABOVE STUDENT IS DIAGNOSED WITH DIABETES. THIS FORM WILL ASSIST IN THE MANAGEMENT OF HIS/HER DIABETES AND SHOULD BE KEPT IN THE STUDENTS MEDICAL FILE AND TAKEN ON ALL FIELD TRIPS ALONG WITH THE STUDENTS MEDICATION.

STUDENT NAME: ____________________________D.O.B:________________GRADE:____________
STREET: _________________________________CITY:__________________ZIP:__________________

TREATING PHYSICIAN____PHONE:___________________

PRIMARY CONTACT
PARENT/GUARDIAN:___________________________________
CELL:__________________________ HOME:_________________________ WORK:_______________

SECONDARY CONTACT
NAME:_______________________________________RELATION:_______________________________
CELL:_____________________________ HOME:____________________ WORK:_________________

BLOOD GLUCOSE MONITORING

Target range for blood glucose

☐ ____mg/dl. to _____mg/dl.
☐ 80-110 m
☐ 70-130 mg/dl
☐ 70-180 mg/dl

Student's self-care blood glucose checking skills

Independently Checks
Check with Supervision
Requires school nurse or trained personnel to check

TIMES TO CHECK BLOOD GLUCOSE

☐ With symptoms of Hypoglycemia

☐ With symptoms of Hyperglycemia

☐ Before breakfast/lunch/snack. _______ hours after food

☐ Before/after exercise (sports/physical education/recess)

☐ As needed for signs/symptoms of illness

☐ Two (2) hours after a correction dose or specify ______ hrs. after correction dose

Contact parent/guardian if blood glucose is **less than 70** or **greater than 400** (Always **treat student first** and then call home)

HYPOGLYCEMIA (LOW BLOOD SUGAR) <70

☐ Headache, Shakiness, Blurry vision, Irritability, Confusion, Dizziness, Hunger, Weakness, Drowsiness, Sweating, Behavior change, Slurred speech, Poor coordination, Paleness, Anxiety, Loss of consciousness, Seizure, Other____

HYPERGLYCEMIA (HIGH BLOOD SUGAR) > 250

☐ Thirst, Frequent Urination, Fatigue, Feels Tired/Sleepy, Blurred Vision, Confused, Unconscious, Weak, Labored breathing, Dry mouth, Nausea, Vomiting, Hungry, Flushing of skin, Lack of concentration, Sweet/fruity breath, Inability to swallow, Other____

ACTION FOR HYPOGLYCEMIA TREATMENT < 70

☐ 2-4 glucose tablets OR Tabs or juice choice per parent instruction
☐ 4 ounces of juice
☐ Glucose gel (using finger, place between cheek & gum in mouth)-1/2 tube
☐ If no meal or snack within the next hour, then give a 15 gram snack
☐ Contact school nurse

SEVERE HYPOGLYCEMIA TREATMENT

☐ Glucose gel or cake decorating gel ½ tube between cheek & gum
☐ Glucagon (give o.5mg/1mg SQ in the arm or thigh
☐ Call 911
☐ Call parent/guardian
☐ Contact school nurse

HYPERGLYCEMIA TREATMENT > 250

☐ Provide water & access to bathroom
☐ Test urine ketones if blood glucose is greater than 250 twice in a row. Call parent if moderate to large
☐ See below for insulin instructions if applicable

Child should not be sent home from school with elevated blood glucose UNLESS child is too ill from the acute illness and/or has moderate ketones and vomiting present

INSULIN

USUAL LUNCH TIME DOSE: Base dose of Humalog/Novolog, Regular insulin at lunch (circle type of rapid/short-acting insulin used) is _______units or does flexible dosing using ______units/_____grams carbohydrate

Use other insulin at lunch (please list type and units)____

INSULIN CORRECTION DOSES

_____Units if blood glucose _____ to _____mg/dl
_____Units if blood glucose _____ to _____mg/dl
_____Units if blood glucose _____ to _____mg/dl
_____Units if blood glucose _____ to _____mg/dl
_____Units if blood glucose ______ to ______mg/dl

FOR STUDENTS WITH INSULIN PUMP

Correction Factor___________________________
Type of pump_______________________________
Insulin/carbohydrate ratio_________________)____
Is student competent regarding use of pump yes/no
Can student troubleshoot problems (pump malfunctions) yes/no

Can student give own injections? Yes/No
Can student determine correct amount of Insulin? Yes/No
Can student draw correct dose of insulin? Yes/No
If student becomes unconscious, having a seizure (convulsion), or unable to swallow

Administer_____________________**Dosage**_____________**Route**_____________**and call 911.**

AGREEMENT:

- I am requesting permission for my child named above to receive medication in accordance with this action plan. I will assume responsibility for safe delivery of the medication/drug to school. The medication but be brought to school in the container in which it was dispensed by the prescriber or licensed pharmacist.
- I will notify the school immediately if there is any change in the use of the medication or prescribed treatment. A revised action plan will need to be on file signed by the prescriber.
- I release and agree to hold the Board of Education, it's officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization

SIGNATURES: Represent agreement with the above information and action plan

PARENT/GUARDIAN: ______________________________________**DATE:**_________________

LICENSED PRESCRIBER: __________________________________**DATE:**_________________

SCHOOL NURSE: ____**DATE:**_________________

5/10
4/4/14