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**DIABETES ACTION PLAN: Residential & Non-Residential Students**

(IF APPLICABLE)

* This page is required **ONLY** if your child has a current diagnosis of Diabetes OR provide your own action plan
* This section MUST be completed by the Diabetes Care Provider (not the parent/guardian)

**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diabetes Care Provider Information:**

Diabetes Care Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Type 1  Type 2 Insulin Pump?  Yes  No Blood Glucose Target Range: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Blood Sugar Testing Times** (check all that apply): \_\_\_\_\_ before all meals \_\_\_\_\_ at bedtime \_\_\_\_\_ other:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diabetes Medication:**

Long Acting Insulin: \_\_\_\_\_ YES \_\_\_\_\_ NO Name/Dosage/Frequency of Long Acting Insulin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Short Acting Insulin: \_\_\_\_\_ YES \_\_\_\_\_ NO Name/Dosage/Frequency of Short Acting Insulin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Corrective Dose Scale/Calculation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When to use scale/calculation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Dose Scale/Calculation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When to use scale/calculation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oral Medication: \_\_\_\_\_ YES \_\_\_\_\_ NO Name/Dosage/Frequency of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise/Sport Activity:**

May participate in PE classes? \_\_\_ YES \_\_\_ NO May participate in after school sports? \_\_\_ YES \_\_\_ NO

Snack should be eaten if blood glucose is under \_\_\_\_\_\_\_. Exercise should be delayed if BG is higher than \_\_\_\_\_ or lower than \_\_\_\_\_

**Hypoglycemia:** Hypoglycemia is a blood sugar less than \_\_\_\_\_\_\_\_\_\_.

 Give immediate sugar source (4 glucose tablets, ½ cup fruit juice or regular pop, 1 fruit rollup, 5-6 lifesavers or glucose gel).

 If blood sugar is less than 50 give 2 sugar source treatments.

 Wait 15-20 minutes. Re-test & re-treat until blood sugar is in target range.

 If low before a meal/snack: treat to get back in range before allowing student to go to meal.

* If indicated, bolus for food eaten at meal.
* Do not give corrective dose after treatment of a low blood sugar.

 Notify parent/guardian of low blood sugar & treatment.

**Hypoglycemia/Treatment for Unconscious/Seizing Student:**

 Administer Glucagon  1 Vial  ½ Vial

 Call 911.

 Test blood sugar every 10 minutes.

 If student arouses prior to EMS arriving, give sips of regular soda and crackers.

 Do not give any liquids or food while unresponsive.

 Notify parent/guardian.

**Hyperglycemia:** Hyperglycemia is a blood sugar greater than \_\_\_\_\_\_\_\_\_\_.

 If blood sugar is greater over \_\_\_\_\_\_\_ check urine for ketones.

 Allow unrestricted bathroom privileges.

 Encourage extra sugar free liquids (water, diet drinks).

* Negative/Trace/Small Ketones: 8-12 oz every ½ to 1 hour (inform parent/guardian for trace/small ketones).
* Moderate/Large Ketones: Notify parent/guardian and/or Diabetes provider.

 Student should NOT participate in exercise-related activities.

 Call parent/guardian and/or Diabetes provider if vomiting occurs.

**Comments/Special Instructions:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIABETES CARE PROVIDER SIGNATURE PROVIDER PRINTED NAME DATE**

I, the parent/guardian, give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact the diabetes care provider if necessary and for this form to be faxed/emailed to my child’s school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with the prescribed medication and delivery/monitoring devices:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE PARENT/GUARDIAN PRINTED NAME DATE**

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*