

This page is required **ONLY** if your child has a current diagnosis of Diabetes OR your provider may provide his/her own Action Plan
2020-2021

DIABETES ACTION PLAN: Residential & Non-Residential Students

- This section **MUST** be completed by the Diabetes Care Provider (not the parent/guardian)

Student's Name: _____

PLEASE CHECK ALL THAT APPLIES:

<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 Blood Glucose Target Range: _____ Does student have an Insulin Pump? <input type="checkbox"/> Yes <input type="checkbox"/> No Type of Pump (if applicable): _____ Blood Sugar Testing Times: _____ before all meals _____ at bedtime _____ Other (please list): _____	
<p>Diabetes Medication:</p> Long Acting Insulin: <input type="checkbox"/> Yes <input type="checkbox"/> No Name/Dosage/Frequency: _____ Short Acting Insulin: <input type="checkbox"/> Yes <input type="checkbox"/> No Name/Dosage/Frequency: _____ Oral Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Name/Dosage/Frequency: _____ Corrective Dose Scale/Calculation (if applicable): _____ When to use scale/calculation: _____ Food Dose Scale/Calculation (if applicable): _____ When to use scale/calculation: _____	
<p>Exercise/Sports Activity:</p> May participate in PE classes? <input type="checkbox"/> Yes <input type="checkbox"/> No May participate in after school sports? <input type="checkbox"/> Yes <input type="checkbox"/> No Student should not participate in exercise/physical activity if: _____ Blood glucose is above _____ or below _____ _____ Ketones are moderate or large _____ Other: _____	
<p>Hypoglycemia (conscious student):</p> Hypoglycemia is a blood sugar less than _____. <input type="checkbox"/> Give immediate sugar source <ul style="list-style-type: none"> • If BS is less than 50 give (2) sugar sources. • 3-4 glucose tabs or ½ cup fruit juice or regular pop. <input type="checkbox"/> Recheck BS & treat with a sugar source every 15-20 minutes until BS is in target range. <ul style="list-style-type: none"> • If indicated, bolus for food eaten at meal. • Do not give corrective dose after treatment for a low blood sugar. <input type="checkbox"/> Notify parent/guardian of low blood sugar & treatment.	<p>Hyperglycemia:</p> Hyperglycemia is a blood sugar greater than: _____. <input type="checkbox"/> If BS is greater than _____, check urine for ketones. <ul style="list-style-type: none"> • See ketone management below. <input type="checkbox"/> Encourage extra sugar-free liquids (water, diet drinks). <input type="checkbox"/> Student should not participate in exercise-related activities if BS is greater than _____ and has moderate or large ketones.
<p>Hypoglycemia (unconscious or seizing student):</p> <input type="checkbox"/> Administer Glucagon _____ 1 vial _____ ½ vial <ul style="list-style-type: none"> • If glucagon is not available, place frosting/glucose gel in the side of cheek & massage cheek <input type="checkbox"/> Call 911 <input type="checkbox"/> Test blood sugar every 10 minutes until EMS arrives <input type="checkbox"/> If student arouses & is able to swallow prior to EMS arriving, give sips of regular soda with crackers <ul style="list-style-type: none"> • Do not give liquids while unresponsive <input type="checkbox"/> Notify parent/guardian	<p>Ketone Management:</p> Negative/Trace/Small Ketones: <ul style="list-style-type: none"> • No additional insulin in required. • Student may participate in exercise-related activities. • Allow unrestricted bathroom privileges. • Encourage extra sugar-free liquids (8 - 12 oz every ½ to 1 hour). • Notify parent/guardian of elevated BS & ketone level. Moderate/Large Ketones: <ul style="list-style-type: none"> • Notify diabetes provider and/or parent/guardian. • Student should NOT participate in exercise-related activities. • Allow unrestricted bathroom privileges. • Encourage extra sugar-free liquids (same as above) • Notify parent/guardian.
<p>Self-Administration: (please check one)</p> <input type="checkbox"/> Student can carry & use the medication listed above at school without supervision. <input type="checkbox"/> Student needs supervision or assistance with the above medication at school.	

Physician/Provider:

Address: _____ Date: _____
 Phone #: _____ Fax #: _____ Email: _____
 Provider Signature: _____ Provider Printed Name: _____

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/mailed 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 Signature: _____ Parent Printed Name: _____

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