

# Diabetes Action Plan

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

Bus #: \_\_\_\_\_ Bus Driver: AM: \_\_\_\_\_ PM: \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_ Type 1 ☐ Type 2 ☐ Date of Plan \_\_\_\_\_

Needs assistance: ☐ None With: \_\_\_\_\_

Notify parents in the following situations: \_\_\_\_\_

Location of student's diabetes supplies: \_\_\_\_\_

## Blood Glucose Monitoring

Target range for blood glucose is: \_\_\_\_\_ Usual times to check blood glucose are: ☐ Before meals ☐

Before afternoon snack ☐ If student feels "low" or ill ☐ Before exercise ☐ After exercise ☐ Other \_\_\_\_\_

- For BG below \_\_\_\_\_ before exercise, give 15 grams carbohydrate snack without insulin.
- For BG below \_\_\_\_\_ give 15 grams fast acting carbohydrate and recheck blood glucose in 15 minutes.
- If BG is still below \_\_\_\_\_ treat again and call parent/guardian.
- If student has BG over \_\_\_\_\_ with urine ketones, notify parent/guardian.

## Medications

☐ Oral Diabetes Medication: \_\_\_\_\_ When Taken: \_\_\_\_\_

**Insulin to be given only with food unless otherwise directed by parent.**

Types of insulin: ☐ Humalog ☐ Novolog ☐ Other \_\_\_\_\_ ☐ Insulin Pen

Usual dose for carbohydrates coverage: \_\_\_\_\_ units for every \_\_\_\_\_ grams of carbohydrate.

Insulin for blood glucose correction: Formula: (BG minus \_\_\_\_\_) divided by \_\_\_\_\_ equals number of units to give.

Other correction: \_\_\_\_\_

☐ Student has an insulin pump Type of Pump: \_\_\_\_\_

Type of insulin in pump: ☐ Humalog ☐ Novolog ☐ Other \_\_\_\_\_

Insulin to carbohydrate ratio and high blood sugar correction programmed into meter per students needs.

Other pump instructions: \_\_\_\_\_

☐ If pump failure occurs or if student has blood sugar more than \_\_\_\_\_ with urine ketones, give insulin per injection to cover high blood sugar and notify parent/guardian.

**Diet:** ☐ Regular ☐ Other: \_\_\_\_\_

☐ **Changes and updates to student's diabetes medication and care may be communicated to the school by the parent/guardian in writing. Parent/guardian is responsible for communicating the level of supervision for their child that is required by school personnel for blood glucose monitoring and insulin administration.**

**GLUCAGON:** For severe hypoglycemic (low blood sugar) reaction (loss of consciousness, seizure), give:

- ☐ 1.0 mg IM ☐ 0.5 mg IM

Turn on side and observe for vomiting. When alert, may treat low blood sugar with 15 grams carbohydrate. **If GLUCAGON IS REQUIRED, ADMINISTER IT PROMPTLY AND CALL 911 AND THE PARENT/GUARDIAN.**

**Physician's Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print/Stamp physician name, address and phone number:**

## Diabetes Action Plan (con't)

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DOB: \_\_\_\_\_

School: \_\_\_\_\_

Grade/Teacher: \_\_\_\_\_

All medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

### Parent Permission

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for one year, unless revoked.

I give permission to the school nurse and other designated staff members of Johnston County Schools to perform and carry out the tasks as outlined by this Diabetes Action Plan. I also consent to the release of the information contained in this Diabetes Action Plan to all staff members and other adults who have custodial care of my child and who need to know this information in order to maintain my child's health and safety.

### EMERGENCY CONTACTS: Name/Relation

1. \_\_\_\_\_ a) home \_\_\_\_\_ b) work \_\_\_\_\_ c) cell \_\_\_\_\_

2. \_\_\_\_\_ a) home \_\_\_\_\_ b) work \_\_\_\_\_ c) cell \_\_\_\_\_

3. \_\_\_\_\_ a) home \_\_\_\_\_ b) work \_\_\_\_\_ c) cell \_\_\_\_\_

### EMERGENCY PLAN

1. Recognize when the student is having a **low blood sugar** reaction. Some children with low blood sugar may experience:

Hunger appears pale irritability, crying sweating trembling

dizziness inability to concentrate, confusion

Steps to take when a low blood sugar is suspected:

- **NEVER LEAVE THE STUDENT ALONE OR ALLOW HIM/HER TO LEAVE THE CLASSROOM ALONE.**
- Check the blood sugar, if possible.
- When in doubt, treat for low blood sugar.
- Observe level of consciousness, **if unconscious administer glucagon if ordered by the physician, and call 911 for emergency assistance.**
- If conscious, give a "fast sugar" such as: 2 teaspoons sugar; regular soft drink; fruit juice with sugar (1/2 to 2/3 cup); small tube of cake frosting.
- After 15 minutes, recheck the blood sugar. If improved, give protein snack (cheese, peanut butter crackers, milk). Fast sugar may be repeated if blood sugar does not improve within 15 minutes.
- Always notify parent/guardian of the low blood sugar episode.
- Additional information: \_\_\_\_\_

2. Recognize when the student is having a **high blood sugar** reaction. Some children with high blood sugar may experience:

Thirst frequent urination fatigue/sleepiness increased hunger

Blurred vision stomach pains lack of concentration sweet fruity breath

Steps to take when a high blood sugar is suspected:

- Check blood sugar, ketones and give insulin as indicated
- Allow free use of the bathroom
- Encourage student to drink water
- Exercise

### Acknowledged and received by:

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Parent Email address \_\_\_\_\_ Parent Phone Numbers \_\_\_\_\_

School Nurse's Signature \_\_\_\_\_ Date \_\_\_\_\_