Blue Springs School District
Diabetic Action Plan

Student's Name:_____ **DOB:**_____ **School Year:**_____

Contact Information:

Parent/Guardian:_____ Day Phone:_____
Cell Phone:_____
Parent/Guardian:_____ Day Phone:_____
Cell Phone:_____
Emergency Contact:_____ Day Phone:_____
Cell Phone:_____

Blood Glucose Monitoring:

Target range for blood glucose is: ____70-150 ___70-180 ___Other:_____

Usual times to check blood glucose:_____

Times to do extra blood glucose checks (*check all that apply)*

- _____Before exercise
- _____After exercise
- _____When student exhibits symptoms of hyperglycemia *(List symptoms on Page 2)*
- _____When student exhibits symptoms of hypoglycemia *(List symptoms on Page 2)*
- _____Other (explain):_____

Can student perform own blood glucose checks? _____Yes _____No

Type of blood glucose meter student uses: _____

Insulin:

Usual Lunchtime Dose:

Name of rapid-/short-acting insulin used:_____

Base dose of insulin at lunch is ___units **OR**

Flexible dosing using ____unit(s)/per_____ grams of carbohydrates

Use of other insulin at lunch (circle type of insulin used): intermediate / NPH / lente _____units of basal / Lantus / Ultralente _____units.

Insulin Correction Doses:

_____Yes _____No Parental authorization should be obtained before administering a correction dose for high blood glucose levels.

_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl

Can student give own injections? _____Yes _____No
Can student determine correct amount of insulin? _____Yes _____No
Can student draw/dial correct dose of insulin? _____Yes _____No

Students with insulin pumps:

Date student received first pump:_____
Type of current pump:_____ Basal rates: _____12 am to _____
_____ _____ to _____
_____ _____ to _____

Type of insulin in pump:_____
Type of infusion set:_____
Insulin/carbohydrate ratio:_____Correction factor:_____

Student Pump Abilities / Skills:	***Needs Assistance:***	
Count carbohydrates	____Yes	____No
Bolus correct amount for carbohydrates consumed	____Yes	____No
Calculate and administer corrective bolus	____Yes	____No
Calculate and set basal profiles	____Yes	____No
Calculate and set temporary basal rate	____Yes	____No
Disconnect pump	____Yes	____No
Reconnect pump at infusion set	____Yes	____No
Prepare reservoir and tubing	____Yes	____No
Insert infusion set	____Yes	____No
Able to change pump site	____Yes	____No
Troubleshoot alarms and malfunctions	____Yes	____No

Students taking Oral Diabetes Medication:

Type of medication/dose:_____ Time: _____

Meals and Snacks Eaten at School:

Is student independent in carbohydrate calculations and management? _____Yes _____No
Will student have a scheduled snack during the school day? _____Yes _____No
If student will have a scheduled snack, please list time(s):_____

Exercise & Sports:

Restrictions on activity, if any:_____
Student should not exercise if blood glucose level is:
Below_____ mg/dl or above_____ mg/dl or if moderate to large urine ketones are present.

Hypoglycemia (Low Blood Sugar):

Usual symptoms of hypoglycemia:_____
Treatment of hypoglycemia: _____
Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow:
Route:_____, Dosage_____, site for glucagon injection:____arm, ____thigh, ___other:_____
If glucagon is required, administer it promptly. Then, call 911 and the parents/guardians.

Hyperglycemia (High Blood Sugar):

Usual symptoms of hyperglycemia:_____

Treatment of hyperglycemia:_____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones:

Trace:_____

Moderate:_____

Large:_____

Supplies parents/guardians will provide and keep at school:

____ Blood glucose meter
_____ Blood glucose test strips
_____ Extra batteries for glucose meter
_____ Lancet device & lancets
_____ Urine ketone strips
_____ Insulin pump (Extra batteries, set-up to change site location if needed)
_____ Fast-acting source of glucose
_____ Carbohydrate containing snacks
_____ Protein containing snacks
_____ Glucagon emergency kit

As supplies kept at school run low, what is the best way to contact you?

_____ *Email:* _____
_____ *Call at work:* _____
_____ *Call Cell phone/leave message*_____
_____ *Call Home/leave message:*_____
_____ *Other:*_____

Signatures:

I give permission to the school nurse and/or trained staff member to perform and carry out the diabetes care tasks as outlined in this diabetes medical management plan for the current school year through summer school. I also consent to the release of information contained in this Diabetes Medical Management Plan to all staff members who care for my student and may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

_____ _____
Parent/Guardian Signature Date

_____ _____
Physician's Signature Date

_____ _____
Reviewed by School Nurse Date