THE ST. PAUL'S SCHOOLS ACTION PLAN FOR DIABETES – 2021-2022 ACADEMIC YEAR

Student: _____ DOB: _____ Grade: _____

CONTACT INFORMATION:

Parent/Guardian: _____ Relationship:

Home Phone: _____ Work: _____ Mobile:

Parent/Guardian: _____ Relationship:

Home Phone: _____ Work: _____ Mobile:

Alternate Contact: _____ Relationship:

Home Phone: _____ Work: _____ Mobile:

Please note that the alternate contact should be a grandparent or other relationship who can act on the student's behalf in the event that the primary parents/guardians cannot be reached.

Insulin Orders (complete only if Insulin is needed at school:

1. Insulin administration via:

   □ Syringe and vial □Insulin Pen □ Insulin Pump □ Other If

   Insulin Pump: type of pump: _____

   Basal Rate: _____

2. Insulin before lunch/meals: _____Name of Insulin: _____

   □ Routine lunchtime/meal dose: _____units

   □ Per sliding scale as follows:

   Meals

   Blood Glucose: _____ to Give: _____ units

   Blood Glucose: _____ to Give: _____ units

   Blood Glucose: _____ to Give: _____ units

   Blood Glucose: _____ to Give: _____ units

   Blood Glucose: _____ to Give: _____ units

   Blood Glucose: _____ to Give: _____ units

   Blood Glucose: _____ to _____ Give: _____ units

   □ Calculate Insulin dose (add carbohydrate coverage and correction dose for total Insulin dose:

   Carbohydrate Coverage: Insulin to carbohydrate ratio

   Give _____unit(s) insulin per _____gms carbohydrate

   Correction:

   Give _____unit(s) Insulin per _____mgs/dl of glucose above _____mg/dl

   Subtract _____unit(s) Insulin per _____mg/dl of glucose below _____mg/dl

   □ Insulin may be given after lunch if: _____

3. Other times Insulin may be given:

   □ Snack: Dose: _____Calculate as above

   □ Snack: Blood Glucose: _____Give: _____units

   Blood Glucose: _____Give: _____units

   □ Ketones: If Ketones are: _____Give/Add: _____units

Health Care Provider Authorization Management of Diabetes in School

My signature below provides authorization for the above written orders. This authorization is for a maximum of one school year. If changes are indicated, I will provide new written authorization, which may be faxed/emailed.

Health Care Provider Name:

Signature: _____

Phone Number: _____

Parent Consent for Management of Diabetes at School

I (We) request the designated school personnel to administer the medication and treatment orders as prescribed above. I agree 1. To provide the necessary supplies and equipment, and 2. To notify the school nurse if there is a change in the student's diabetes management or healthcare provider.

Parent Signature: _____Date: _____

Order reviewed and signed by School Nurse:

Signature: _____Name: _____Date: _____