CHARLOTTE CHRISTIAN SCHOOL
veritas tota | homini toti

DIABETES ACTION PLAN | 2022-23

Health Room Fax #: (704) 368-1078

STUDENT

First: ____

Last: ____

DOB: ____________________________ Grade: ________

PARENT

Parent's Names: ____________________________________

Father Cell: ____________________________________

Mother Cell: ____________________________________

Emergency Contact Name: ________________________________
(other than parent)

Emergency Contact Number: ____________________________

TO BE COMPLETED BY PHYSICIAN

#1 - BLOOD SUGAR CHECKS

Target Blood Sugar Range ______ to ______.

Select one: ☐ Student can perform checks independently **OR**
☐ Requires school nurse assistance.

Check all that apply for times to check BG:

- ☐ Before lunch
- ☐ After lunch
- ☐ Before snack
- ☐ After snack
- ☐ Before P.E.
- ☐ After P.E.
- ☐ As needed for signs of low or high blood sugar
- ☐ Other: __________________

☐ If checked, use Dexcom G6/G5 readings to dose insulin. If signs/symptoms do not match Dexcom readings, perform fingerstick blood sugar.

Glucometer Type/Brand: ______________________________

Supplies/glucometer will be kept: ☐ In the health room
☐ With the student

#2 - INSULIN ADMINISTRATION

Insulin administered by: ☐ Pen ☐ Syringe ☐ Pump

Type of Insulin:
- ☐ Humalog
- ☐ Novolog
- ☐ Regular
- ☐ Other: ______________________________

Meals and snacks: ____ Units for every ____ grams of carbohydrates eaten

Correction Dose?
- ☐ No
- ☐ Yes, please select one of the following:
  - ☐ ____ Units for every ____ mg/dl points above ____ mg/dl
  - ☐ BOLUS per pump recommendations

#3 - HYPOGLYCEMIA - BLOOD SUGAR LESS THAN ______ MG/DL

Symptoms of hypoglycemia: dizziness, shaking, anxiety, hunger, blurry vision, weakness/fatique, headache, behavior changes, pallor, loss of consciousness, seizure.

This student may also exhibit: ____

If student presents with symptoms check BG. If BG level is below ______, treat with ______ grams of fast acting sugar (glucose tabs, juice or snack provided by health room.) Recheck BG in 15 minutes, treat again until BG is greater than ______.

SEVERE HYPOGLYCEMIA: BG BELOW ______.

Indications for use of Glucagon: unconsciousness, drowsy, inability to swallow by mouth.
Administer GLUCAGON: ______ mg/IM/SQ/Intranasal. **CALL 911 and notify parent.**

#4 - HYPERGLYCEMIA - BLOOD SUGAR GREATER THAN ______ MG/DL

Symptoms of hyperglycemia: increased thirst, frequent urination, hunger, fatique, irritability, double vision, nausea/vomiting, abdominal pain.

This student may also exhibit: ____

If student presents with symptoms check BG. If BG level is over ______ mg/DL and it has been greater than ______ hours since the last insulin dose.

- Give insulin per sliding scale/BOLUS per pump recommendations.
- Give 8 - 16 oz of water per hour.
- Recheck BG in two hours and treat with sliding scale insulin as needed.
- When having symptoms of nausea/vomiting, student will be released from school to parent/guardian.

Check ketones if BG is over ______ mg/DL for ______ hours. If ketones are present notify the parent/guardian.

When student has insulin pump:
- Blood sugar greater than 300 mg/DL with ketones or two consecutive unexplained blood sugars greater than 300 mg/DL (with or without ketones), may indicate a malfunction in the pump.
- Student may require insulin via injection and/or new infusion site. **PARENTS MUST BE NOTIFIED.**

→ PHYSICIAN SIGNATURE: ______________________________________ DATE: ____________________

PHYSICIAN NAME PRINTED: ______________________________________ PHONE: ____________________

TO BE COMPLETED BY PARENT/GUARDIAN

#5 - STUDENT SELF-CARE

Please select all that apply:

- ☐ Totally independent management
- ☐ Test blood sugar independently
- ☐ Tests and interprets urine/blood ketones
- ☐ Administers insulin independently
- ☐ Self-injects with verification of dose
- ☐ Self-injects mild hypoglycemia
- ☐ Monitors own snacks and meals
- ☐ Independently counts carbohydrates
- ☐ Self-injects with trained staff supervision
- ☐ Injections to be done by trained staff

I authorize the Diabetes Care Team to notify me via the following methods: ☐ Voicemail or text at cell phone: ______________________________
☐ E-mail at: ______________________________

→ PARENT SIGNATURE: ____ DATE: ____________________

ALL MEDICATION WILL BE DISCARDED IF NOT PICKED UP BY MAY 27, 2022.
THE ABOVE MEDICATION ORDER IS VALID FOR ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.