CHARLOTTE CHRISTIAN SCHOOL
veritas tota | homini toti

DIABETES ACTION PLAN

Health Room Fax #: (704) 368-1078

STUDENT

First: _____

Last: _____

DOB: _____ **Grade:** _____

PARENT

Parent's Names: _____

Father Cell: _____

Mother Cell: _____

Emergency Contact Name: _____ **Emergency Contact Number:** _____
(other than parent)

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
☐ If checked, nurse may asisst with inserting a new Dexcom sensor.

#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.
☐ If checked, the nurse may change the insulin pump/infusion site/cartridge or use injection until dismissal.

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 THE LAST DAY OF SCHOOL.
THE ABOVE MEDICATION ORDER IS VALID FOR ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.