

School Year

20_____

ELIZABETHTON CITY SCHOOLS

DIABETES ACTION PLAN

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To be completed by
Parent/Guardian/School Nurse
Please print

Child Information:

Name: _____ Date of Birth: _____

School: _____ Grade: _____ Homeroom Teacher: _____

Emergency Information: Date of Care Plan: _____

Parent/Guardian Names: _____

Mother's Phone #: Cell _____ Work _____

Father's Phone #: Cell _____ Work _____

In the event a Parent/Guardian cannot be reached, please list other adults that may be contacted in the event of an emergency that may pick up your child and/or accompany your child to the Emergency Room if needed.

1. Name: _____ Relation: _____ Telephone: _____

2. Name: _____ Relation: _____ Telephone: _____

Student Medical Information:

Student's Primary Physician: _____ Office #: _____

Address: _____

ALLERGIES: ☐ NO ☐ YES (specify): _____

TYPE OF DIABETES: ☐ TYPE I (Insulin Dependent) ☐ TYPE 2 (List RX meds taken) _____

BLOOD GLUCOSE MONITORING

- Student's target range: _____ mg/dl to _____ mg/dl
- Usual time(s) to check blood sugar: _____
- **Contact parent if blood sugar is below:** _____ mg/dl or above _____ mg/dl
- Student's ability to check blood sugar : ☐ Needs assistance ☐ Independent
- Student lunch time: _____
- Child's ability to count carbohydrates: ☐ Needs assistance ☐ Independent

INSULIN ADMINISTRATION

My child takes Insulin at school: By Injection By Insulin Pump Insulin Pen

☐ My child does not take Insulin at school

Types of Insulin: ☐ Humalog ☐ Novolog ☐ Other (please list): _____

Student's ability to administer insulin as prescribed by Health Care Provider (HCP):

☐ Student is independent (**must have HCP note stating that student is self care**).

☐ Student requires assistance.

For students on insulin pumps only:

- Type of pump: _____
- Troubleshooting the pump alarms and codes:
☐ Student is independent ☐ Student requires assistance ☐ Call parent for assistance

HYPOGLYCEMIA (Low blood sugar)

Student's usual symptoms of Low Blood Sugar (Hypoglycemia) check all that apply:

☐ Hungry ☐ Weakness or Fatigue ☐ Headache ☐ Dizzy ☐ Fast Heartbeat

☐ Shaky ☐ Irritable ☐ Blurry Vision ☐ Sweating ☐ Other: _____

If the student exhibits the above symptoms he/she should be accompanied to the nurse's office or main office for monitoring.

Will Glucagon be given at school? ☐ Yes (Doctor order needed) ☐ No

HYPOGLYCEMIA (Continued)

Hypoglycemia treatment:

- Give student glucose tablets, sugar packets or 4 oz of juice** (if alert and able to swallow).
- If student is conscious, but unable to swallow, instant glucose gel** will be given if available.
- Repeat blood sugar in 15 minutes and refer to HCP orders.
- If Glucagon is available it will be administered per the HCP orders. If the student becomes unconscious and/or is seizing, 911 will be called and the Parent will be notified.
- Other (be specific): _____

**** It is the parent's responsibility to provide the school with hypoglycemia treatment snacks to have available at all times.**

HYPERGLYCEMIA (High blood sugar)

Student's usual symptoms of High Blood Sugar (Hyperglycemia) check all that apply:

- ☐ Extreme Thirst ☐ Urinates Often ☐ Drowsy ☐ Hungry ☐ Blurry Vision
☐ Other: _____

Hyperglycemia treatment:

- Refer to HCP instructions for treatment of Hyperglycemia and list here (be specific):

- Check ketones if blood sugar greater than: _____ mg/dl
- Call parent if ketones greater than: _____ mg/dl
- Student needs to drink water and allowed to have water available in the classroom
- Frequent bathroom breaks as needed.
- Call HCP as needed for instructions.
- Other (be specific): _____

I understand that it is my responsibility to keep this information current and to provide an updated form on at least an annual basis. I agree to maintain an adequate supply of medication at school. I give my permission for school personnel, who volunteer under no duress and are trained by a Registered Nurse, to participate in the care of my child in the event a school nurse is not present. I hereby agree and understand that the Elizabethton City School system and its personnel shall not be held liable for any injury resulting from the reasonable and prudent assistance in the administration of medication/treatment to my child. I give permission for the school nursing staff to share protected healthcare information with other school staff members on a need to know basis.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date _____

School Nurse Signature: _____ Date _____

Staff Members Trained:

Name	Title	Location/Room	Trained By (RN only)

School Year

20_____

ELIZABETHTON CITY SCHOOLS

DIABETES ACTION PLAN

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Physician to Complete

Please print

CHILD INFORMATION:

NAME: _____ DATE OF BIRTH: _____

Parent/Guardian Name: _____

Address: _____

ATTENDING PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

DIAGNOSIS: ☐ Diabetes Type I ☐ Diabetes Type II

For Students taking oral meds: Name of medication: _____ Time given: _____

BLOOD GLUCOSE MONITORING:

Target range for glucose is _____ mg/dl to _____ mg/dl

Usual times to check blood sugar: ☐ Before meals ☐ After exercise ☐ With symptoms of hyperglycemia

☐ With symptoms of hypoglycemia ☐ Other (please specify): _____

Can Student perform own blood glucose checks? ☐ Yes ☐ No

Type of glucometer student uses: _____

FOR STUDENT WITH INSULIN PUMP:

Type of pump: _____

Can student troubleshoot the pump alarms and codes?

☐ Student is independent ☐ Student requires assistance ☐ Call parent for assistance

Type of Insulin in pump: _____ Basal rate: _____ 12 a.m. to _____

_____ to _____

_____ to _____

Insulin/Carbohydrate ratio: _____ Correction Factor: _____

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Additional notes (be specific): _____

INSULIN:

Base dose of (check appropriate box): ☐ Humalog ☐ Novolog ☐ Regular

at lunch is _____ units **or** does flexible dosing using _____ units/ _____ grams carbohydrates.

Use of insulin other than lunch (be specific): _____

INSULIN CORRECTION DOSES:

_____ 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 the correct amount of insulin? ☐ Yes ☐ No

Can student draw up the correct dose of insulin? ☐ Yes ☐ No

EXERCISE AND SPORTS:

Restrictions on activity, if any: _____

Student should not exercise if blood glucose is below _____ mg/dl or above _____ mg/dl or if _____

Urine Ketones are present.

Physician to Complete
Please print**CHILD INFORMATION:**

NAME: _____ DATE OF BIRTH: _____

HYPOGLYCEMIA :**Student's usual symptoms of Low Blood Sugar (Hypoglycemia) check all that apply:**

- ☐ Hungry ☐ Weakness or Fatigue ☐ Headache ☐ Dizzy ☐ Fast Heartbeat
☐ Shaky ☐ Irritable ☐ Blurry Vision ☐ Sweating ☐ Other: _____

If the student exhibits the above symptoms he/she should be accompanied to the nurse's office or main office for monitoring.

HYPOGLYCEMIA TREATMENT: For Blood Sugars below _____ mg/dl

- ☐ Give student glucose tablets, sugar packets or 4 oz of juice** (if alert and able to swallow).
☐ If student is conscious, but unable to swallow, instant glucose gel** should be given if available.
☐ Repeat blood sugar in 15 minutes.

Will Glucagon be given at school? ☐ Yes ☐ No***Glucagon dosage _____ mg or _____ unit (circle appropriate method):** Subcutaneous IM IV**If severe hypoglycemia symptoms persist:**

- ☐ If Glucagon is available it should be given if the student is unconscious, having a seizure or is unstable. If Glucagon is required, administer it promptly and call 911 and notify Parent/Guardian. If Glucagon is unavailable, call 911 immediately. Notify parent/guardian.
☐ Other (be specific): _____

HYPERGLYCEMIA:**Student's usual symptoms of High Blood Sugar (Hyperglycemia) check all that apply:**

- ☐ Extreme Thirst ☐ Urinates Often ☐ Drowsy ☐ Hungry ☐ Blurry Vision
☐ Other: _____

HYPERGLYCEMIA TREATMENT:

- ☐ Check ketones if blood sugar greater than: _____ mg/dl
☐ Call Parent/Guardian if ketones greater than _____ mg/dl

Treatment for ketones:

- Small Ketones: _____
- Moderate Ketones: _____
- Large ketones: _____
- Student needs to drink water and allowed to have water available in the classroom.
- Frequent bathroom breaks as needed.
- Call HCP office as needed for instructions.

THIS DIABETES ACTION PLAN HAS BEEN APPROVED BY:**HEALTHCARE PROVIDER SIGNATURE:** _____ **DATE:** _____

I give permission for the Elizabethton City School nursing staff and my child's HealthCare provider to exchange protected healthcare information in order to clarify and/or maintain an Emergency Care Plan for my child.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____**SCHOOL:** _____ **PHONE:** _____**SCHOOL NURSE:** _____ **FAX:** _____