

THE ST. PAUL'S SCHOOLS ACTION PLAN FOR DIABETES

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: _____