

's Diabetes Action Plan

Date: _____

Child's Name _____

Child's DOB: _____

Child Care/School: _____ Teacher: _____ Classroom/Gr.: _____

1) Parent/Guardian: _____ Phone: (w) _____ (c) _____ (h) _____

2) Parent/Guardian: _____ Phone: (w) _____ (c) _____ (h) _____

3) Emergency contact: _____ Phone: (w) _____ (c) _____ (h) _____

Physician: _____ Phone: _____ Fax: _____

Diabetes Information

<u>Hyperglycemia (High Blood Sugar)</u>	<u>Hypoglycemia (Low Blood Sugar)</u>
<i>Not enough insulin in the body to allow sugar to be used</i>	<i>Usually happens before lunch or after exercise</i>
<ul style="list-style-type: none"> • Excessive thirst • Flushed dry skin • Frequent urination • Tired • Blurred vision • Excessive hunger • Fruity odor to breath • Fatigue • Weakness • Vomiting 	<ul style="list-style-type: none"> • Weakness, fatigue • Feeling faint • Dizziness • Shaky, trembling • Nausea • Rapid pulse • Excessive hunger • Abdominal pain • Confusion • Anxious, Irritability • Sweaty, Pallor • Slurred speech

First Aid for High Blood Sugar or Low Blood Sugar

<u>Hyperglycemia (High Blood Sugar)</u>	<u>Hypoglycemia (Low Blood Sugar)</u>
<ol style="list-style-type: none"> 1. Check the blood sugar if signs & symptoms occur. 2. Check Urine for Ketones if BS above _____ 3. Stay with child continuously 4. Provide water to drink, allow unlimited use of bathroom 5. Call parent if: <ul style="list-style-type: none"> • blood sugar is above _____ • ketones are <input type="checkbox"/> moderate or <input type="checkbox"/> high • experiencing nausea/vomiting 6. Administer insulin per physician's order (see insulin administration orders) 7. Recheck blood sugar in _____ minutes and at _____ intervals. 8. Call 911 if: <ul style="list-style-type: none"> • child loses consciousness • unable to reach parent and symptoms worsen 9. Stay with child continuously. <p style="margin-top: 20px;">ADDITIONAL PUMP INSTRUCTIONS</p> <ul style="list-style-type: none"> • Check pump function • Check pump site • Check tubing • Treat for Hyperglycemia as above <p style="margin-top: 20px;">____ Parent initials</p> <p style="margin-top: 20px;">ADDITIONAL INFORMATION _____</p>	<ol style="list-style-type: none"> 1. Check blood sugar if signs & symptoms occur. 2. Stay with the child continuously. 3. Give the carbohydrate supplement ordered by the physician if blood sugar is less than _____ and child is conscious, cooperative, and able to swallow. <ul style="list-style-type: none"> • Give _____ grams carbohydrate. Examples: _____ 4. Check blood sugar after 15 minutes. <ul style="list-style-type: none"> • If blood sugar does not improve, give fast sugar again. • When symptoms improve, provide an additional snack of _____. • If still no improvement after (2) two fast sugars, call physician and call parent to pick up child. 5. Call 911, the parents, and the child's physician, if: <ul style="list-style-type: none"> • the child's symptoms do not subside • the child loses consciousness • unable to reach parent and symptoms worsen 6. Give Glucagon _____ mg injection if child is unconscious, experiencing a seizure or unable to swallow. (Place student on side.) 7. When conscious and able to swallow 4 oz. of juice may be given until EMS arrives. <p style="margin-top: 20px;">ADDITIONAL PUMP INSTRUCTIONS: _____</p> <p style="margin-top: 20px;">____ Parent initials</p> <p style="margin-top: 20px;">ADDITIONAL INFORMATION _____</p>

Diabetes Management at School or Childcare Facility

Blood Glucose Monitoring

Due to the variety of glucose meters, follow the manufacturer's instructions carefully.

Target Blood Sugar Range: _____ mg/dl to _____ mg/dl
 Usual times to check blood sugar: Before snack Before lunch Before PE After recess/PE Other
 Can the child check his/her own blood sugar? Yes No With Assistance
 Can the child check his/her own ketones: Yes No With Assistance

Insulin

Does student require assistance with carbohydrate counting?

Yes No

Can child give his/her own injections and/or operate pump?

Yes No With Assistance

Types of insulin taken: _____ Pen Pump Injection
 Usual times of insulin injections: _____ Basal Rate if on pump: _____
 Amount of insulin to give: _____ (If a sliding scale is used, physician must order below.)

Giving Insulin

Pumps:

Does student know how to:

Change tubing Yes No

Change batteries Yes No

Change insulin cartridge Yes No

Decide bolus amt Yes No

Give bolus Yes No

- 1) Using the glucose meter, check the blood sugar.
- 2) Document blood sugar in log book and notify parent/guardian as indicated under **First Aid for hypo/hyperglycemia.**
- 3) Administer insulin using following calculations (sliding scale plus ratio amount):

Units of Insulin to Give Based on

Sliding Scale of Blood Sugar Reading

PLUS*

Insulin/Carbohydrate Ratio

Blood Sugar 150-200 = ____ Units

Ratio: ____ Units insulin per ____ Carbs

Blood Sugar 201-250 = ____ Units

Blood Sugar 251-300 = ____ Units

Blood Sugar 301-350 = ____ Units

Blood Sugar 351-400 = ____ Units

Blood Sugar > 401 = ____ Units

** IF GREATER THAN _____ CALL PARENT & MD **

Qualified Staff

DCM or trained by RN

Staff qualified to use glucose meter: _____
 Staff qualified to give insulin injections and/pr operate pump: _____

Supplies Location

Diabetes care supplies are kept: _____
 Supplies of snack foods kept : _____
 Additional (**emergency**) supplies are kept: _____

Food and Exercise

Meals/Snacks

Time

Food Content / Amount

Breakfast	_____	_____
Mid-Morning	_____	_____
Lunch	_____	_____
Mid-Afternoon	_____	_____
Before Exercise	_____	_____
After Exercise	_____	_____
Other	_____	_____

Preferred Snacks:

Foods to Avoid:

Student should not exercise if blood sugar is below ____ mg/dl OR above ____ mg/dl.

Other exercise/activity instructions: _____

Exercise and Sports or Activity Limits (including any school sponsored event)

Child should not participate in active play if blood sugar is below ____ mg/dl or above ____ mg/dl.

Physical activity restrictions / limitations / accommodations: _____

Physician's Order

Required

This diabetic management plan has been approved by:

 Physician Signature _____ to _____
 Effective Dates

Parent Signature

Required

 Parent Signature _____ Date