PAPILLION LA VISTA
COMMUNITY SCHOOLS

STUDENT DIABETES ACTION PLAN
Effective Dates: ____________________

Name: _______________________ **Age:** _____ **DOB:** _______ **Grade/Teacher:** __________

Parent/Guardian(s) : ____

Home Phone: ___________________________ **Work Phone:** __________________________

Medical Provider's Name: ____________________________ **Phone:** ___________________

Date of Diagnosis: ____________________

NOTIFY PARENT / GUARDIAN IN THE FOLLOWING SITUATIONS:

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BLOOD GLUCOSE MONITORING

Target range of blood glucose: _______________________________

Does student have a CGM? Yes / No

If yes, can CGM be used for insulin dosing? Yes / No

Can student perform own manual blood glucose tests? Yes / No

Exceptions: ____

Usual times to test blood glucose: _____________________________

Times to do extra tests (check all that apply):

- ☐ Before exercise
- ☐ When exhibits symptoms of hyperglycemia
- ☐ After exercise
- ☐ When exhibits symptoms of hypoglycemia
- ☐ Other (specify): ____

FOR STUDENTS TAKING ORAL DIABETIES MEDICATION AT SCHOOL

Type and time(s) of medication: ____

FOR STUDENTS WITH INSULIN PUMPS

Type of pump: _______________________________________

Is student competent regarding pump? Yes / No

Can student effectively troubleshoot problems (e.g. ketosis, pump malfunction)? Yes / No

Times, type, and dosage of insulin injections to be given during school:

Time	*Insulin Type*	*Dosage*
_____________	_____________	_____________
_____________	_____________	_____________

FOR STUDENTS WITH INSULIN PEN/SYRINGE
Times, types, and dosages of insulin injections to be given during school:

Time	*Insulin Type(s)/Syringe/Pen*	*Dosage*
______________	_________________	______________
______________	_________________	______________

Can student give own injections? Yes / No
Can student determine correct amount of insulin? Yes / No
Can student draw up correct dose of insulin? Yes / No
Does student need supervision for the above? Yes / No

MEALS/SNACKS AT SCHOOL

Meal/Snack	*Time*	*Food content/amount*
Breakfast	_________	________________________________
A.M. Snack	_________	________________________________
Lunch	_________	________________________________
P.M. Snack	_________	________________________________

Correction Factor: ______________ Insulin to Carbohydrate ratio: ______________

Is student independent in carbohydrate calculation and management? Yes / No
Is student allowed to have special occasion snacks when provided to classroom? Yes / No

EXERCISE (PE / RECESS) AND SPORTS
Snack *before* exercise? Yes / No
Snack *after* exercise? Yes / No
Restrictions on activity, if any: ____
Student should not exercise if blood glucose level is below _________mg/dl *OR* above _________mg/dl
Or if small, moderate or large ketones are present.

HYPOGLYCEMIA (LOW BLOOD SUGAR)
Usual symptoms of hypoglycemia: ____

Treatment of hypoglycemia: ____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.
If Glucagon is given, 911 will be called and the parent will be notified.

HYPERGLYCEMIA (HIGH BLOOD SUGAR)
Usual symptoms of hyperglycemia: ____

Treatment of hyperglycemia: ____

Circumstances when urine or blood ketones should be tested: _____________________________________

Treatment for ketones: ____

In absence of moderate/large ketones, correct for high blood sugar outside of meals? Yes / No

If yes, correction factor: ______________

SUPPLIES

Parent(s) maintain responsibility for routine maintenance of diabetic equipment. Parent(s) are responsible for providing school with the supplies necessary to care for student during the school day. Supplies include, but may not be limited to:

- ☐ Insulin, syringes and/or pen needles
- ☐ Blood sugar meter, strips & lancets
- ☐ Ketone strips, alcohol wipes
- ☐ Food to treat low blood sugar (juice, tabs)
- ☐ Snacks
- ☐ Glucagon kit
- ☐ Extra pump/CGM supplies (if applicable)
- ☐ Batteries and/or charging device (if applicable)
- ☐ Water bottle

** In the event of an emergency and/or the health office is not accessible, the necessary supplies to care and treat the student must be immediately available at all times. Often times, items are placed in a bag that travels with the student.

COMMENTS/OTHER INFORMATION

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SIGNATURES

I give the school nurse permission to speak with the diabetic team as needed:

Parent/Guardian: ____________________________________ **Date:** _____________

Medical Provider: ____________________________________ **Date:** _____________

Reviewed by School Nurse: ____ **Date:** _____________