AISD Health Services

Diabetes Action Plan

Student: ___________________________________ DOB: ___________________ School Year/Grade : ________________

Type of Diabetes: ☐ **Type 1** ☐ **Type 2** ☐ **Other** **Date of Diagnosis:** _______________

Co-Existing Diagnosis: ____

Goals

- Maintain normal insulin/glucose levels. Student, parents and staff will recognize and respond to early problems.
- Maintain communication between school, parents and physician. Student will improve self care management skills.

Diet

Carbohydrate choice = ___________________ Grams of carbohydrate

☐ Meal plan variable

☐ Meal plan prescribed

Snack time: AM _______________ # of carb choices __________________

AM _______________ # of carb choices __________________

Lunch time: _____________________ # of carb choices __________________

Before PE: _____________________ # of carb choices __________________

☐ Extra food allowed: ☐Parent/guardian's discretion ☐ Student's discretion

Blood Testing at School

☐ Before Lunch

☐ After Lunch

☐ After PE

☐ As needed for sign/symptoms Hypo/hyperglycemia

☐ Trained personnel must monitor blood sugar

☐ Student can perform test independently

☐ Student is able to monitor own blood sugar

☐ Call parent if values are Below: ______________ Above: ______________

Low Blood Sugar Reaction – symptoms exhibited by student

☐ Hunger

☐ Shakiness

☐ Sleepiness or confusion

☐ Uncooperative

Student Recognizes symptoms:

☐ YES ☐ NO

☐ Irritability

☐ Sweating

☐ Pallor

☐ Crying or other behavioral changes

When do most reactions occur? __________________________ ____

High Blood Sugar Reaction – symptoms exhibited by student

☐ Extreme Thirst

☐ Abdominal Pain

☐ Flushed skin

Student Recognizes symptoms:

☐ YES ☐ NO

☐ Headache

☐ Increased/frequent urination

☐ Fruity/wine odor breath

When do most reactions occur? __________________________ ____

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Student: ___________________________________ DOB: ___________________ School Year/Grade : ________________

Normal Range of Blood Sugar Levels _________________ to _____________________

If the student complains of Low Blood Sugar – *TEST BLOOD SUGAR LEVEL* – Always stay with the student

If blood glucose results are < _________________________

- ☐ Give 4 ounces of juice or 6 ounces (1/2 can) of *regular* soda or: ______________________________
- ☐ Wait 10 minutes. Recheck blood sugar. Re-Treat as above is still below: ______________________
- ☐ Follow with snack or lunch if still below goal. Notify: ☐ School Nurse ☐ Parent ☐Physician

If student is conscious yet unable to effectively drink fluids offered:

- ☐ Administer ¾ to 1 tube (3 tsp) of glucose gel or
- ☐ ¾ to 1 tube cake decorating gel (place between cheek and gum with head elevated. Encourage student to swallow.)
- ☐ Notify: ☐ School Nurse ☐ Parent ☐Physician

If student is unconscious and had seizures:

- ☐ Stay with student ☐ Protect from injury ☐ Do not put anything in mouth
- ☐ Call 911 ☐ Roll student to side

If the student complains of High Blood Sugar – *TEST BLOOD SUGAR LEVEL* – Always stay with the student

If the blood glucose results are > ________________________

- ☐ Drink 8 ounces of water or DIET soda every hour.
- ☐ Be allowed to carry water with them.
- ☐ Use restroom as often as needed.
- ☐ If blood glucose is above ____________ do not allow to exercise.

If student is ill or vomiting, call parent to pickup.

For confusion, labored breathing or unconscious call 911.

Medications to be given during school hours: Type of Insulin: _____________________________

Insulin administered via: ☐ Syringe ☐ Pump ☐ Pen ☐ Other _____________

Meal bolus: _______________________ units of insulin per __________________________ grams of carbohydrates

Correction dose: ___________________ units of insulin for every ___________ mg/dl above _____________ mg/dl.

Sliding Scale:

Blood Glucose from ____________ to _______________ = ______________ Units
Blood Glucose from ____________ to _______________ = ______________ Units
Blood Glucose from ____________ to _______________ = ______________ Units
Blood Glucose from ____________ to _______________ = ______________ Units
Blood Glucose from ____________ to _______________ = ______________ Units

- ☐ Correction bolus can be given every __________________________ if blood glucose levels are high.
- ☐ Student can use insulin pen
- ☐ Student can draw up and inject own insulin
- ☐ Student cannot draw up own insulin but can give own injection
- ☐ Student needs assistance checking insulin dosage.
- ☐ Student needs insulin administered by a trained adult.
- ☐ Student can independently operate insulin pump.
- ☐ Carry supplies for blood glucose monitoring.
- ☐ Carry supplies for insulin administration.

I give permission for the information contained on the HCAP to be shared with adults in the school setting that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one year or until the health status or physicians orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever this is any change in the student's health status or care.

____ ____________________ ________________________

Physician Signature/Stamp **Date** **Office Number**

____ ____________________ ________________________

Parent/Guardian Signature **Date** **Contact Number**