# DIABETES ACTION PLAN

Kearney Public Schools

Date of plan: _____ School year: _____

**Student Information**

Student Name:_____ Date of birth: _____ Grade: _____
Date of diabetes diagnosis: _____ Type 1_____ Type 2_____

**Parent/Guardian Information**

ParentGuardian 1: _____
Telephone: Cell: _____ Work: _____ Home: _____
Email: _____

ParentGuardian 2: _____
Telephone: Cell: _____ Work: _____ Home: _____
Email: _____

**Student's physician/health care providers**

Primary care physician: _____ Phone: _____
Diabetes educator: _____ Phone: _____
Other: _____ Phone: _____

**Blood Glucose Monitoring**

_____ Student independently checks own blood glucose
_____ Student requires assistance with checking blood glucose
_____ Student uses a smartphone or Continuous Glucose Monitor (CGM)

**Target range of blood glucose**

Before Meals: _____ Other: _____

**Check blood glucose level:**

When student is to check blood glucose level:

_____

_____

_____

_____

_____

**Hypoglycemia (LOW blood sugar)**
Signs/symptoms of hypoglycemia: _____
_____

Treatment of hypoglycemia: _____
_____
**Snacks to be provided by parent*

Glucagon is to be given under the following circumstances: (911 will be called and parents will be notified in this situation, per school policy) _____
_____

No PE/sports if blood sugar is below: _____

Call parent if blood sugar is below: _____

**If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate. Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.*

**Hyperglycemia (HIGH blood sugar)**
Signs/symptoms of hyperglycemia: _____
_____

Treatment of hyperglycemia: _____
_____

Urine/Blood (circle) ketones should be checked under these circumstances: _____
_____

No PE/sports if blood sugar is above: _____

Call parent if blood sugar is above: _____

**If the student has symptoms of a hyperglycemia emergency, call 911 and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy or depressed level of consciousness.*

**Insulin therapy at school** _____ N/A
_____ Student independently calculates and administers own insulin
_____ Student requires assistance with insulin administration

**Insulin delivery device**
____ Syringe/Pen _____ Pump

**Fixed insulin** _____ N/A
_____ Units of insulin to be given pre-breakfast daily
_____ Units of insulin to be given pre-lunch daily
_____ Units of insulin to be given _____ daily

**Sliding Scale insulin**_____ N/A
Name of insulin: _____
1 unit of insulin per _____ grams of carbohydrate
**Correction dose** outside of meals: _____
_____

**When to give insulin**
Breakfast
Carbohydrate coverage only
Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
Other: _____

Lunch
Carbohydrate coverage only
Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
Other: _____

Snack
No coverage for snack
Carbohydrate coverage only
Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

Correction dose only
For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.

Other: _____

**Special event/party food permitted**: ____ Parent/guardian discretion ____ Student discretion

**Snacks**

| Meal/Snack | Time | Carbohydrate Content (grams) |
|---|---|---|
| Breakfast | _____ | _____ to _____ |
| Mid-morning snack | _____ | _____ to _____ |
| Lunch | _____ | _____ to _____ |
| Mid-afternoon snack | _____ | _____ to _____ |
| Other _____ | _____ | _____ to _____ |

**Signatures**

This Diabetes Medical Management Plan has been approved by:

_____

*Student's Physician/Health Care Provider* Date

I, (parent/guardian) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) _____ to perform and carry out the diabetes care tasks as outlined in (student) _____ Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

_____

Student's Parent/Guardian Date

_____

Student's Parent/Guardian Date

_____

School Nurse/Other Qualified Health Care Personnel Date