School Nurse Verify & Initial:

_____ MD signature obtained

_____ Medication Authorization Form on file

_____ Teacher/Staff trained & signatures on file

Type 1 Diabetes Action Plan

Student ____ **Grade** _______________

Mother ______________________________________**Home Phone** _______________**Work/Cell** _____________

Father _______________________________________**Home Phone** ______________ **Work/Cell** _____________

Emergency Contacts

Name____**Relationship**_______________ **Phone**________________

Name____**Relationship**_______________ **Phone**________________

Other medical diagnosis or conditions:

____

Parent(s) or guardian(s) must supply all necessary blood glucose monitoring materials. Materials include:

____

____

Name of glucose meter student is using:

____

Blood glucose target range
Low _____________________________ **to** ______________________________ **High**

☐ **Notify the treating physician if blood glucose is out of range.**

☐ **Notify parent/guardian if the blood glucose is out of the target range.**

Insulin Regimen: type/dose/frequency

____

Does student receive additional insulin based on Blood Glucose results?
☐ **Yes** ☐ **No** **If yes, specify:**

____

Student will perform Self Blood Glucose Monitoring:

☐ **daily, before lunch**

☐ **when student feels low**

☐ **when the student exhibits the following signs and symptoms of Hypoglycemia or low blood sugar:**

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Plan for Hypoglycemia or Low Blood Sugar

Signs and symptoms of Low Blood Glucose:

Weakness	Shaking	Sweating	Hunger
Sleepy	Moody	Pale skin/glassy eyes	Crying
Irritability	Confusion	Headache	

***Unconsciousness or seizure possible if symptoms are not treated.**
Other S/S specific to this child: ____
____

Fast acting carbohydrates should be readily available at all times and should be administered immediately when student presents with symptoms of low blood sugar with or without the student performing blood glucose monitoring.

1. **If Blood Glucose is less than _______________________________**

Treat with <u>one</u> of the following <u>fast acting carbohydrates</u> in the following quantities:

☐ **_______ oz. apple or orange juice** ☐ **_______ # glucose tablets**

☐ **_______ oz. soda with sugar** ☐ **Other _____________________**

☐ **_______ oz. milk**

2. **If lunch or snack is > than 1 hour away, also give <u>one</u> of the following <u>complex carbohydrates</u> in the following quantities:**

☐ **_______ # graham cracker squares** ☐ **_______ # saltine crackers**

☐ **_______ # pieces of bread or toast** ☐ **Other __________________**

3. **Repeat blood glucose test in _________ minutes at _________ intervals until blood glucose level is at target range.**
4. **Repeat <u>fast acting</u> or <u>complex carbohydrates</u> if symptoms persist or resume within 15 minutes.**
5. **Blood sugar out of range → Action: notify parent/guardian**
6. **If the student experiences loss of consciousness or a seizure → Action: call 911 and notify parents**

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Plan for Hyperglycemia or High Blood Sugar

Signs and symptoms of High Blood Glucose: ***(circle all that apply)***

Thirst	Fatigue	Sunken Eyes
Flushed Face	Urinating more or with increased frequency	

Other S/S specific to this child: ____

____

☐ **Send notification home to parent/guardian if blood glucose is > than _______________.**

☐ **Call parent/guardian if blood glucose is > than ___________________.**

☐ **Other ____.**

<u>Delay recreational activity if:</u>

☐ **Blood Glucose is > than __________________________**

☐ **Blood Glucose is < than __________________________**

Diet Restriction

☐ **Do not add sugar or sweets to lunch or routine snacks.**

☐ **Substitute canned fruit with fresh fruit ___________________.**

☐ **Other ____**

<u>Other Restriction if:</u>

☐ **Blood Glucose is > than _____________ Restriction:________________________________**

☐ **Blood Glucose is < than _____________ Restriction:________________________________**

General Comments:

____

____

____

*****Physician has authorized student to self-carry and self-administer diabetic supplies including, but not limited to blood glucose strips, ketone strips, insulin pen and/or vial, glucagon medication, and sharps. Yes _____ No _____***

Physician Signature: ____ **Date:** ______________________

Parent/Guardian Signature: ____ **Date:** ______________________

Nurse Signature: ____ **Date:** _______________________

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