



Health Services Department

Diabetic Action Plan

Student Name: _____ Grade: _____ School Year: _____

Parent/Guardian Name: _____ Contact Number: _____

Physician Name: _____ Contact Number: _____

Blood Glucose Monitoring:

Target range for blood glucose is: _____ Correct if blood glucose is above: _____

Usual times to check blood glucose: _____

Times to do extra blood glucose checks (check all that apply)

- Before exercise
 After exercise
 When student exhibits symptoms of hyperglycemia
 When student exhibits symptoms of hypoglycemia
 Other (explain): _____

Can student perform own blood glucose checks? YES NO

Type of blood glucose meter student uses: _____

Insulin:

Rapid Acting Insulin Type: _____

- Dosing Timing:
 _____ minutes before eating
 New diagnosis-correction ONLY at mealtime
 At start of meal/snack
 After meal/snack complete

Breakfast _____ unit per _____ grams of carbohydrates ISF: _____ mg/dL

Mid-AM snack _____ unit per _____ grams of carbohydrates

Lunch _____ unit per _____ grams of carbohydrates

Mid-PM snack _____ unit per _____ grams of carbohydrates

Insulin Correction Doses:

Parental authorization should be obtained before administering a correction dose for high blood glucose levels. YES NO

Correction instructions: _____

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Can student give their own injections? YES NO
Can student determine correct amount of insulin? YES NO
Can student draw correct dose of insulin? YES NO

Students with insulin pumps:

Date student received first pump: _____

Type of current pump: _____

Basal rates: _____ 12 am to _____
 _____ to _____
 _____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Level of Diabetes Management Independence

Requires nurse/adult administration of doses/blood glucose testing YES NO

Needs adult assistance/supervision with diabetes related activities YES NO

May manage diabetes related activities independently YES NO

Students taking Oral Diabetes Medication:

Type of medication/dose: _____ Time: _____

Exercise & Sports:

Restrictions on activity, if any: _____

Student should not exercise if blood glucose level is:

below _____ mg/dl or above _____ mg/dl or if moderate to large urine 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, or unable to swallow:

Route: _____, Dosage _____, site for glucagon injection: arm thigh other: _____

If glucagon is required, administer it promptly. Then, call 911 and the parents/guardians.

Hyperglycemia (High Blood Sugar):

Usual symptoms of hyperglycemia: _____

Treatment of hyperglycemia: _____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones:

Trace: _____

Moderate: _____

Large: _____

Supplies parents/guardians will provide and keep at school:

Blood glucose meter

Blood glucose test strips

Extra batteries for glucose meter

Lancet device & lancets

Urine ketone strips

Insulin pump (Extra batteries, set-up to change site location if needed)

Fast-acting source of glucose

Carbohydrate containing snack-(may include protein snack)

Glucagon emergency kit

As supplies kept at the school run low, what is the best way to contact you?

Email: _____

Call at work: _____

Call cell phone/leave message: _____

Other: _____

Signatures:

I give permission to the school nurse to perform and carry out the diabetes care tasks as outlined in this diabetes medical management plan for the current school year through summer school. I also consent to the release of information contained in this Diabetes Medical Management Plan to all staff members who care for my student and may need to know this information to maintain my child's health and safety.

Parent/Guardian Signature (required): _____ **Date:** _____

Physician Signature (required): _____ **Date:** _____