DIABETES ACTION PLAN
Fairless Local Schools 2026-2027

Student's Name: _____ **Date of Birth:** _____
Grade: _____ **Home Room Teacher:** _____

Location of supplies: Blood glucose monitor _____ Insulin supplies _____
Snack foods _____

Blood Glucose Monitoring
Contact parent if blood glucose is less than _____ or greater than _____.
Student can perform own blood glucose checks without supervision. _____Yes _____No
Times to check blood glucose *(check all that apply):*
_____ with symptoms of hypoglycemia – low blood sugar - (shaky, sweaty, confused)
_____ with symptoms of hyperglycemia - high blood sugar - (thirsty, frequent urination)
_____ before lunch, _____(time)
_____ before/after exercise
_____ other, please specify _____
Usual symptoms of low blood sugar _____
****EMERGENCY**Low Blood Sugar – (Hypoglycemia) treatment** – *(check all that apply):*
_____ 2-4 glucose tablets
_____ 4 oz of juice, _____(type)
` _____ glucose gel (using finger place between cheek & gum in mouth) ½ tube
_____ other, please specify _____
_____

It is parent's responsibility to provide the school with low blood sugar treatment snacks to have available at all times!! School will notify parent when supply is low.
Usual symptoms of high blood sugar _____
High Blood Sugar – (Hyperglycemia) treatment _____
Insulin – *(Check **all** that apply):*
_____ Student not taking insulin at school
_____ Student takes insulin at school
_____ SC Insulin _____ Humalog
_____ Insulin via insulin pump _____ Novolog
_____ Insulin with lunch _____ Humulin R
_____ Insulin with snack _____ Other, _____(type)
_____ Student may give own injections: ____ without supervision ____ with supervision
_____ Give _____ units of Humalog/Novalog/Humulin R SQ if glucose is > _____.
_____ Give insulin according to current scale for elevated blood glucose
_____ Student may determine correct dose of insulin
_____ School to administer insulin
_____ Student using insulin pump & may give bolus: ____ without supervision ____ with supervision
Snacks – *(Check **all** that apply):*
Please allow a _____ gram snack at _____am
Please allow a _____ gram snack at _____pm
Please allow a _____ gram snack prior to gym class
Please allow a _____ gram snack at _____
Instructions for when food is provided to the class, such as part of a class party or food sampling:
_____
Special Instructions: _____
_____
_____

_____ _____ _____
Physician's Signature (required) **Physician's Printed Name** **Date**

_____ _____
Physician's Address **Physician's Phone Number**

I authorize school personnel to implement this management and emergency plan as described above.

_____ _____
Parent/Guardian Signature **Date**