



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:** _____