Kearney Public Schools
Health Services
Diabetes Action Plan

DATE: ______________

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Student's Name: ____ Grade: _____ School: _____________

Date of Birth: ___________ Date of Diabetes Diagnosis: __________________

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

CONTACT INFORMATION:

Mother/Guardian: ____

Telephone: Home - ____________________ Work - ______________________ Cell - _____________________

Father/Guardian: ____

Telephone: Home - ____________________ Work - ______________________ Cell - _____________________

Student's Doctor/Health Care Provider: Name: ____

Address: ____

Telephone: ___________________________________ Emergency Number: ___________________________________

Notify parents/guardian in the following situations: ____
____

HYPOGLYCEMIA (Low Blood Sugar)

Usual Symptoms of hypoglycemia: ____
____

Treatment of hypoglycemia: ____
____

<u>Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.</u>

Route ____, Dosage _____, site for glucagon injection: ____ arm, ____ thigh, _______________other.

<u>If glucagon is required, administer it promptly. Then call 911 (or other emergency assistance), the school nurse, and the parents/guardian.</u>

HYPERGLYCEMIA (High Blood Sugar)

Usual Symptoms of hyperglycemia: ____
____

Treatment of hyperglycemia: ____
____

Urine should be checked for ketones when blood glucose level is above __________ mg/dl.

Treatment for ketones:

None Present: ______________________ Small: ________________________

Moderate: _________________________ Large: ________________________

BLOOD GLUCOSE MONITORING

Target range for blood glucose is: ☐ 70-150 ☐ 70-180 ☐ other ________________

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

Exceptions: ____

Type of blood glucose meter student uses:____

INSULIN

Usual Mealtime Dose

Base dose of regular Humalog/Novalog (circle type) insulin at **breakfast** is ____ units or does flexible dosing using ____ units/____grams of carbohydrate.

Use of other insulin at breakfast: intermediate NPH/Lente (circle type) ____ units or basal Lantus/Ultralente ____ units.

Base dose of regular Humalog/Novalog (circle type) insulin at **lunch** is ____ units or does flexible dosing using ____ units/ ____ grams carbohydrate.

Use of other insulin at lunch: (circle type): intermediate NPH/Lente ____ units or basal Lantus/Ultralente ____ units.

Use of other insulin in **evening**: (circle type): intermediate NPH/Lente ____ units or basal Lantus/Ultralente ____ units.

PHYSICIAN AUTHORIZATION FOR INSULIN ADJUSTMENT:

Parents are authorized to adjust the insulin dosage under the following circumstances: ____________________________
____

INSULIN CORRECTION DOSES:

____ units if blood glucose is _____ to _____ mg/dl

____ units if blood glucose is _____ to _____ mg/dl

____ units if blood glucose is _____ to _____ mg/dl

____ units if blood glucose is _____ to _____ mg/dl

____ units if blood glucose is _____ to _____ mg/dl

Can student give own injections? ☐ Yes ☐ No
Can student determine correct amount of insulin? ☐ Yes ☐ No
Can student draw correct dose of insulin? ☐ Yes ☐ No

FOR STUDENTS WITH INSULIN PUMPS:

Type of pump: ____________________________

Basal rates: ____ 12 a.m. to ____
____ ______ to ____
____ ______ to ____

Type of insulin in pump: ____

Type of infusion set: ____

Insulin/carbohydrate ratio: __________________________________ Correction factor: _____________________

Student Pump Abilities/Skills:	Needs assistance	
Count carbohydrates	☐ Yes	☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes	☐ No
Calculate and administer corrective bolus	☐ Yes	☐ No
Calculate and set basal profiles	☐ Yes	☐ No
Calculate and set temporary basal rate	☐ Yes	☐ No
Disconnect pump	☐ Yes	☐ No
Reconnect pump at infusion set	☐ Yes	☐ No
Prepare reservoir and tubing	☐ Yes	☐ No
Insert infusion set	☐ Yes	☐ No
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS:
Type of medication: ____ Timing: _________________________
Other medications: ____ Timing: _________________________

MEALS AND SNACKS EATEN AT SCHOOL:
Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Meal/Snack	Time	Food content/amount
Breakfast	________________________	____
Mid-morning snack	________________________	____
Lunch	________________________	____
Mid-afternoon snack	________________________	____
Dinner	________________________	____

Snack before exercise: ☐ Yes ☐ No Snack after exercise: ☐ Yes ☐ No
Other times to give snacks and content/amount: ____
Preferred snack foods: ____
Foods to avoid, if any: ____
Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):
____

EXERCISE AND SPORTS
A fast-acting carbohydrate such as ____ should be available at the site of exercise or 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.

SUPPLIES TO BE KEPT AT SCHOOL

________ Blood glucose meter, blood glucose test strips, batteries for meter
________ Lancet device, lancets, gloves, etc.
________ Urine ketone strips
________ Insulin pump and supplies
________ Insulin pen, pen needles, insulin cartridges
________ Fast-acting source of glucose
________ Carbohydrate containing snack
________ Glucagon emergency kit

LOCATION OF SUPPLIES AT SCHOOL

____

____

SIGNATURES:

This Diabetes Action Plan has been approved by:

____ _________________________________
Student's Physician/Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of ___________________________ School to perform and carry out the diabetes care tasks as outlined by _____________________'s Diabetes Action Plan. I also consent to the release of the information contained in this Diabetes Action Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also authorize the school nurse to discuss this Diabetes Action Plan and matters pertinent to ______________________________'s diabetic condition with the above-named health care provider.

Acknowledged and received by:

____ _________________________________
Student's Parent/Guardian Date

____ _________________________________
Student's Parent/Guardian Date