

DIABETES INFORMATION ACTION PLAN
Health Services
Lincoln Public Schools

INFORMATION FOR PARENTS AND GUARDIANS: If the condition named above affects your child, we request that you complete, sign and return this form to the school health office.

- Sharing this information is important to keeping your child safe, and providing correct emergency response, at school.
- It is very important we have current emergency contact information for you.
- Written authorization from your child's physician is required for medically necessary cares at school (if any are needed, including medications). A new authorization is required for each school year and when medical orders change.

BY SIGNING BELOW YOU ACKNOWLEDGE THE FOLLOWING:

- You are providing your written consent to provide treatments to your student as described.
- You are providing your written consent to administer medications as described.
- If needed, the prescribing physician may be contacted by the school nurse for additional information or clarification on medication administration and cares at school.
- Information will be shared as appropriate with other school personnel to benefit your child's safety and educational success at school.

Student Name: _____ ID#: _____ Grade: _____

Date of Birth: _____ Homeroom Teacher: _____

Date of Diabetes Diagnosis: _____ ☐ Diabetes Type I ☐ Diabetes Type II

Parent/Guardian Signature _____ Date: _____

CONTACT INFORMATION

Parent/Guardian #1 Name: _____ Address: _____ Phone: _____	Parent/Guardian #2 Name: _____ Address: _____ Phone: _____
Emergency Contact #1 Name: _____ Address: _____ Phone: _____ Relationship: _____	Emergency Contact #2 Name: _____ Address: _____ Phone: _____ Relationship: _____
The Doctor Managing Your Child's Diabetes: Name: _____ Clinic Group: _____ Phone: _____ / Fax: _____	Hospital Preference: (We cannot guarantee where your child will be taken in the event of an emergency): _____ Your Child's Diabetic Educator (if your child has one): _____

INDIVIDUALIZED PLAN
COMPLETE ALL OF THE FOLLOWING THAT APPLIES:
HYPOGLYCEMIA MANAGEMENT (Low Blood Sugar)

Usual Signs of Hypoglycemia: _____

Treatment of Hypoglycemia (specify blood sugar ranges as needed): _____

☐ Glucagon is to be Administered Under the Following Circumstances:

Note: If glucagon is administered, 911 and parents/guardian will be summoned to the school.

HYPERGLYCEMIA MANAGEMENT (High Blood Sugar)

Usual signs of Hyperglycemia: _____

Treatment of Hyperglycemia (specify blood sugar ranges as needed): _____

☐ Urine or Blood Ketones Should be Checked with the following symptoms _____ or
when blood glucose levels are above _____ mg/dl.

BLOOD GLUCOSE MONITORING

Target Range: _____

Preferred Anatomical Site(s) for Taking Sample (finger, forearm, rotation schedule): _____

Preferred School Location for Performing Blood Glucose Tests: _____

Type of Glucometer Used by Student: _____

EXERCISE AND SPORTS

☐ Parent/Guardian Will Provide to appropriate school staff a Fast-Acting Carbohydrate such as _____

☐ Restrictions on Activity, if any: _____

☐ Student Should Not Exercise if Blood Glucose is Below _____ mg/dl.

☐ Student Should Not Exercise if Moderate to Large Ketones are Present at School (if tested).

MEALS AND SNACKS AT SCHOOL

☐ Snack Foods or Fast-Acting Carbohydrate such as _____ are Provided by the Parent/Guardian.
Location: _____

☐ Instructions When Food is Provided to the Class (e.g. as part of a class party or food sampling event): _____

☐ Low carbohydrate or "free snacks" will be provided by parent and kept _____

☐ Instructions for Field Trips: _____

☐ Student May Carry a Fast-Acting Carbohydrate Such as _____ for Self-Administration.

Student Name: _____ ID #: _____

MEDICATIONS
ORAL MEDICATIONS

Name of Medication: _____ Dose: _____ Time: _____

Name of Medication: _____ Dose: _____ Time: _____

INJECTABLE INSULIN

Name of Insulin: _____ Method of Injection: _____

Other Injectable Medications (if applicable): _____

☐ Insulin Correction/Sliding Scale for Blood Glucose Reading:

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

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

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

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

☐ Adjust Insulin Dose to Carbohydrate for School Breakfast Intake Using _____ Units of Insulin per _____ Grams of Carbohydrate.

☐ Adjust Insulin Dose to Carbohydrate for School Lunch Intake Using _____ Units of Insulin per _____ Grams of Carbohydrate.

Maximum Bolus Dose of Insulin _____ Units (if applicable).

Parent/Guardian Signature (or medical authorization) Required for Dose Changes: only the licensed nurse can accept a verbal order.

INSULIN PUMP USERS

(Complete insulin correction/sliding scale above if your child's pump needs correction factor manually entered.)

Type of Pump: _____ Type of Insulin in Pump: _____

Maximum Bolus Setting: _____ How Long Has Your student Had an Insulin Pump: _____

DIABETES MEDICAL MANAGEMENT PLAN

May be updated as often as needed. Changes require parent signature and school nurse verification.

Time	Glucose Testing	Snack or Meal	Insulin Type and Dose	Start Date	SN Initial & Date When Verified

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Parents/Guardians please use these checklists to help make certain we are prepared to care for your student.

STUDENT SKILL ASSESSMENT

Check all that student is able to perform reliably and independently (WITHOUT assistance or supervision or that is appropriate to the care):

FOR ALL STUDENTS

- ☐ Count Carbohydrates
- ☐ Perform Own Blood Glucose Checks
- ☐ Check Urine for Ketones
- ☐ Check Blood for Ketones
- ☐ Calculate Corrective Dose of Insulin Based on Carbs
- ☐ Calculate Corrective Dose of Insulin Based on Blood Glucose
- ☐ Draw up Insulin or Set Insulin Dose Device (pen)
- ☐ Self-Administer Insulin by Injection

INSULIN-PUMP USERS ONLY

- ☐ Bolus Correct Amount on Pump for Carbohydrates Consumed
- ☐ Calculate and Set Temporary Basal Rate on Pump
- ☐ Disconnect Pump
- ☐ Reconnect Pump at Infusion Set
- ☐ Prepare Reservoir and Tubing on Pump
- ☐ Insert Infusion Set for Pump
- ☐ Troubleshoot Alarms and Malfunction on Pump

PROVIDED BY PARENT/GUARDIAN

- ☐ Glucometer, Test Strips, Lancets, Control Solution
- ☐ Urine Ketone Strips
- ☐ Blood Ketone Strips
- ☐ Insulin Vials and Syringes
- ☐ Insulin Pump and Supplies
- ☐ Insulin Pen, Pen Needles, Insulin Cartridges
- ☐ Oral medications (specify) _____
- ☐ Fast acting glucose (specify) _____
- ☐ Snacks (specify) _____
- ☐ Glucagon Emergency Kit
- ☐ Physician Authorization for Meds Including Glucose and Insulin
- ☐ Physician Authorization for Procedures Including Blood Glucose Monitoring and Ketone Testing
- ☐ Completed and Signed Diabetes Information Action Plan

This space is for any individualized information about your child you wish to share:

Completed By: _____ Relationship _____ Date: _____