Gothenburg Public School
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

Form updated 4/09