ISD #728 School Health Services

DIABETIC ACTION PLAN

Physician: Complete page 1 **Parent/Guardian: Complete page 2**

Student ______________________________ Date of Birth______________ Grade__________

Blood Glucose Monitoring and Insulin

Blood Glucose Target Number/Range: __________ mg/dl

- Blood Glucose Testing Times: ☐ Pre-snack ☐ Pre-lunch ☐ Pre-dismissal ☐ Pre-gym ☐ Other (Specify)______________
- Snack/Lunch Bolus: ☐ _____ # of units per _____ grams of carbohydrates ☐ per pump
- Correction Scale: ☐ _____ unit per _____ blood glucose points over _____ (see correction scale below) ☐ per pump
- Student can self-administer insulin/manipulate pump: ☐ Yes ☐ No
- Parent may adjust insulin doses as needed: ☐ Yes ☐ No
- Student wears a continuous glucose sensor: ☐ Yes ☐ No

Medications (List all medications student is taking)

	Medication	Strength	Dose	Time	Route	Possible Side Effects
☐ Insulin – type:						
☐ Emergency med:						
☐ Other:						

Hyperglycemia Treatment

High blood glucose > __________ mg/dl

☐ Per pump

☐ Correction insulin (in addition to scheduled meal dose)

Blood Glucose Value	Units of Insulin
Less than _____	
-	
-	
-	
-	
-	
-	
More than _____	

☐Administer insulin per correction scale if more than ____ hours since last injection.

☐ Recheck blood glucose level in 1 hour if blood glucose is >______.

☐ Check ketones if blood glucose is > __________. Notify parent/ guardian if ketones are present.

☐ Notify parent/guardian of blood glucose > ___________.

☐ Additional instructions ______________________________

Hypoglycemia Treatment

Low blood glucose < _______ mg/dl

- Immediately treat with 15 grams of fast-acting carbs (ex: 4 oz. juice or regular pop, 3-4 glucose tablets, fruit snack, 8 oz. skim milk, etc.)

☐ Recheck blood glucose in _______ minutes and repeat treatment if blood glucose remains low.

☐ If student will participate in additional exercise before next meal, student should have another 15 grams of carbohydrates to prevent hypoglycemia.

☐ Notify parent/guardian of blood glucose < _________.

☐ Immediately administer **Glucagon** __________ mg if student is unconscious or having seizures (Glucagon emergency kit)

- Place student on their side as vomiting is a common side effect.
- **Call 911.**
- Notify Parent/Guardian.

☐ Additional instructions ______________________________

Physician Authorization

I authorize the above plan to be followed in school.

Physician's Signature: ______________________ Printed Name of Physician: ______________________ Date: ________

Parent/Guardian: Complete this page

Student ______________________ Date of Birth__________ School ______________ Grade____________

BUS INFORMATION: It is the parent's responsibility to notify the bus company directly of any specific directions for your child's care while riding the bus.

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s) i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my child. I will notify Health Services if I prefer to pick up the medication(s) at school.
6. I understand that this action plan may be revoked at any time and expires in one calendar year.
7. I authorize the above plan to be followed in school.

NOTE: Medication must be supplied in original/prescription bottle.

Parent/Guardian Signature: ______________________ Relationship to Student: ______________ Date: _______

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medication conditions(s) to Health Services personnel.

Parent/Guardian Signature: ______________________________ Date: ________________________