ISD 728 INDEPENDENT SCHOOL DISTRICT 728

ELK RIVER | OTSEGO | ROGERS | ZIMMERMAN

ISD 728: Diabetes Action Plan

School Year:	Student Name:	Date of Birth:
Preferred Hospital:		
Health Care Provider:	Phone:	Fax:

Blood Glucose Monitoring

Blood glucose target range: ________________________ mg/dL					
BG Testing Times:	❏ Pre-snack	❏ Pre-lunch	❏ Pre-dismissal	❏ Pre-gym/recess	❏ Other: _________________
Snack Bolus:	❏ ________ of units per ________ of grams of carbohydrates				❏ per pump
Lunch Bolus:	❏ ________ of units per ________ of grams of carbohydrates				❏ per pump
Correction Scale:	❏ ______ unit per _______ blood glucose points over ______				❏ 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 monitor (CGM):				❏ Yes	❏ No

Medications

	Medication	Strength	Dose	Time	Route	Possible Side Effects
❒ Insulin:						
❒ Emergency:						
❒ Other:						

Signs & Symptoms of Hypoglycemia:

❒ Shaking/trembling ❒ Pallor ❒ Confusion/disorientation

❒ Sweating ❒ Irritability ❒ Hunger/butterfly feeling

❒ Severe headache ❒ Anxious ❒ Tingling sensation

❒ Blurred vision ❒ Rapid heartbeat ❒ Weakness/drowsy

❒ Dizziness/difficulty with coordination ❒ Loss of consciousness

❒ Other: ____

Hypoglycemia Treatment: Blood Glucose below ________ 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 l5 grams of carbohydrates to prevent hypoglycemia.

❒ Notify parent/guardian of blood glucose < _____ mg/dL.

❒ Immediately administer Glucagon _____ mg if student is unconscious or having seizures. Place student on their side as they may vomit. **Call 911**.

❒ Additional Instructions: ______________________________

Signs & Symptoms of Hyperglycemia:

❒ Fruity-smelling breath ❒ Weakness ❒ Nausea and vomiting

❒ Confusion ❒ Coma ❒ Shortness of breath

❒ Dry mouth ❒ Abdominal pain

❒ Other: ____

Hyperglycemia Treatment: Blood Glucose above ___ mg/dL

❒ Per pump ❒ Correction Insulin

Blood Glucose	Units of Insulin	Blood Glucose	Units of Insulin

❒ Administer insulin per correction scale if more than _____ hours since last injection.

❒ Recheck blood glucose level in 1 hour if blood glucose is >______mg/dL

❒ Check ketones if blood glucose is > _______ mg/dL. Notify parent/guardian if ketones are present.

❒ Notify parent/guardian of blood glucose >______ mg/dL.

❒ Additional Instructions: ________________________________

Healthcare Provider Signature**:		Date:	

*****This form provides health care provider authorization for medical treatment to be provided during school hours. The prescribing health care provider is required to complete this document before the services can be provided. Any alteration of the form invalidates the authorization. The student named in this document is under my medical supervision. I have prescribed the following treatment that is necessary to be given during school hours for the child's health or safety. I am also aware that the prescribed treatment may be administered by trained non-medical personnel.***

Parent/Guardian Authorization

1. I request that the above medication/treatment be administered to my child as prescribed by the healthcare provider. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
2. I understand I must provide medication in the original bottle, properly labeled by the pharmacy with the student's name, date, dosage, time and directions for administration.
3. I give permission for the medication(s) to be given by school personnel as delegated by the licensed school nurse.
4. I give permission for the Building Nurse/Licensed School Nurse to consult with my child's physician about any questions regarding the listed medication(s) or medical condition(s) being treated. I understand that the school intends to use the requested information to provide for my child's health and safety needs while at school. I may refuse to supply the requested personal information. The consequence for not providing the information may result in that my child will not be able to take medication during school hours dispensed from the health office. The information I provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.
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 will notify Health Services of any change in the medication(s) i.e. dosage change, medication is discontinued, etc.
7. I understand that the emergency care plan may be revoked at any time in writing and expires in one calendar year.
8. I authorize the emergency care plan to be followed in school.
9. I understand it is my responsibility to notify the transportation company directly of any specific directions for my child's care while riding transportation during the school day.

Parent/Guardian Name:	
Parent/Guardian Signature:	**Date:**