Liberty Public Schools
Diabetic Action Plan

Student's Name________________________________ **Grade**_____ **School Year**________

<u>Contact Information:</u>

Parent/Guardian:______________________________________ Day Phone:_________________
Cell Phone:_________________

Parent/Guardian:______________________________________ Day Phone:_________________
Cell Phone:_________________

Emergency Contact:____________________________________ Day Phone:_________________
Cell Phone:_________________

Emergency Contact:____________________________________ Day Phone:_________________
Cell Phone:_________________

<u>Blood Glucose Monitoring:</u>

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 *(List symptoms on Page 2)*
_____ When student exhibits symptoms of hypoglycemia *(List symptoms on Page 2)*
_____ Other (explain):____

Can student perform own blood glucose checks? _____ Yes _____ No

Type of blood glucose meter student uses:____

<u>Insulin:</u>

<u>Usual Lunchtime Dose:</u>

Name of rapid-/short-acting insulin used:____

Base dose of insulin at lunch is _____ units / or does flexible dosing using _____ unit(s)/ _____ grams of carbohydrates.

Use of other insulin at lunch (circle type of insulin used): intermediate / NPH / lente _____ units of basal / Lantus / Ultralente _____units.

<u>Insulin Correction Doses:</u>

_____ Yes _____No-Parental authorization should be obtained before administering a correction dose for high blood glucose levels.

_____ 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

Students with insulin pumps:

Date student received first pump:____

Type of current pump:_______________________ Basal rates: _______ 12 am 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
Able to change pump site	_____ Yes	_____ No
Troubleshoot alarms and malfunctions	_____ Yes	_____ No

Students taking Oral Diabetes Medication:

Type of medication/dose:_______________________________________ Time: ____________________

Meals and Snacks Eaten at School:

Is student independent in carbohydrate calculations and management? _____ Yes _____ No

Will student have a scheduled snack during the school day? _____ Yes _____No

If student will have a scheduled snack, please list time(s):____________________________________

Exercise & 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.

Hypoglycemia (Low Blood Sugar):

Usual symptoms of hypoglycemia:____

Treatment of hypoglycemia: ____

Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow:

Route:_______, Dosage_______, site for glucagon injection:____arm, ____thigh, ___other:______

If glucagon is required, administer it promptly. Then, call 911 and the parents/guardians.

Hyperglycemia (High Blood Sugar):

Usual symptoms of hyperglycemia:____

Treatment of hyperglycemia:____

Urine should be checked for ketones when blood glucose levels are above ________________mg/dl.

Treatment for ketones:

Trace:____________________________ Moderate:____

Large:____

Supplies parents/guardians will provide and keep at school:

_____ Blood glucose meter
_____ Blood glucose test strips
_____ Extra batteries for glucose meter
_____ Lancet device & lancets
_____ Urine ketone strips
_____ Insulin pump (Extra batteries, set-up to change site location if needed)
_____ Fast-acting source of glucose
_____ Carbohydrate containing snack-(may include protein snack)
_____ Glucagon emergency kit

As supplies kept at school run low, what is the best way to contact you?

_____ *Email:* ______________________________
_____ *Call at work:* ______________________________
_____ *Call Cell phone/leave message* ______________________________
_____ *Call Home/leave message:* ______________________________
_____ *Other:* ______________________________

Signatures:

I give permission to the school nurse to perform and carry out the diabetes care tasks as outlined in this diabetes medical management plan for the current school year through summer school. I also consent to the release of information contained in this Diabetes Medical Management Plan to all staff members who care for my student and may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

______________________________ ______________
Student's Parent/Guardian Date

______________________________ ______________
Physician's Signature Date

______________________________ ______________
Reviewed by School Nurse Date