Diabetes Action Plan

To be completed and signed by Physician

WAVERLY COMMUNITY SCHOOLS
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OFFICE USE ONLY: Effective Date: _____ to _____

Student Name:	Date of Birth:	School Building:	
Parent(s)/Guardian(s):		Phone:	Alternate:
Parent Email(s):		Phone:	Alternate:
Physician Name:		Phone:	Fax:

Checking Blood Glucose

Target Range:
- ○ 70-130 mg/dL
- ○ 70-180 mg/dL
- ○ Other:_____

Preferred site of testing:
- ○ Fingertip
- ○ Forearm
- ○ Thigh
- ○ Other _____

Target Time of Testing
- ○ Mid-morning
- ○ Before Lunch
- ○ ____ hours after Lunch
- ○ Before PE ○ After PE
- ○ Before dismissal
- ○ As needed for low/high glucose
- ○ As needed for illness
- ○ Other: _____

Meter Information
Brand/Model of meter:
_____

Continuous Glucose Monitor (CGM)
○Yes ○ No

If Yes, Brand/Model:
_____
Alarms set for ○ Low ○ High

Meal Plan

Meal/Snack Time Carb Content

Breakfast: _____ ____ to____
Morning Snack: _____ ____ to____
Lunch: _____ ____to____
Afternoon Snack: _____ ____to____
Other _____ ____to____

Special event/party food permitted?
○Yes ○No Notes: _____
_____

Other Diabetes Medications

Name: _____
Dose:_____Route:_____
Time given: _____
Name: _____
Dose: _____Route: _____
Time given: _____

Student Self-Care Checking Skills

Independently checks glucose ○Yes ○No
Check glucose with supervision ○Yes ○No
School Nurse or trained personnel ○Yes ○No

Student Self-Care Nutrition Skills

Independently counts carbs ○Yes ○No
Count carbs with supervision ○Yes ○No
School Nurse or trained personnel ○Yes ○No

Disaster Plan

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parent/guardian.

- ○ Continue to follow these orders
- ○ Additional insulin orders as follows: ____
_____
- ○ Other: _____
_____

Hypoglycemia Treatment

Student's usual symptoms of hypoglycemia: _____
_____

If exhibiting these symptoms OR if glucose level is less than _____mg/dL, give a quick-acting glucose product equal to _____grams of carbohydrate.

Recheck glucose in 10-15 minutes and repeat treatment if blood glucose level is less than _____mg/dL.

Additional treatment: _____
_____

**If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions give:

Glucagon ○ 1mg ○ ½ mg
Route ○ SC ○ IM
Site ○ Arm ○ Thigh ○ Other

Can the student self-carry medication: ○ Yes ○ No

**Call 911 and Parent/Guardian

Hyperglycemia Treatment

Student's usual symptoms of hyperglycemia: _____
_____

Check ○ urine ○ blood ketones every _____ hours when glucose levels are above _____ mg/dL.

For glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin.

Give extra water and/or non-sugar containing drinks (not fruit juices): _____ ounces per hour.

Additional treatment for ketones: _____

Notify parents/guardian of onset of hyperglycemia. If student has symptoms including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness call 911 and parent/guardian.

Physical Activity and Sports

A quick-acting source of glucose such as ○glucose tabs and/or ○sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat ○15 grams ○30 grams ○other _____ of carbohydrate,
○before ○every 30 minutes during ○after vigorous physical activity ○other _____

If most recent glucose is less than _____mg/dL, student can participate in physical activity when blood glucose is corrected and above _____mg/dL.

Avoid physical activity when glucose is greater than _____mg/dL or if urine/blood ketones are moderate to large.

See reverse for Insulin Therapy information

Insulin Therapy

Insulin delivery device: ○syringe ○insulin pen ○insulin pump
Can Student: ○Independently calculate and give injections ○ Calculate and give injections with supervision ○ Requires School Nurse or trained personnel.
Type of insulin therapy at school: ○Adjustable Insulin Therapy ○Fixed Insulin Therapy ○No insulin

Adjustable Insulin Therapy

Name of Insulin: _____

Carbohydrate Coverage

Insulin-to-Carb Ratio: Lunch: 1 unit of insulin per _____grams of carbohydrate
Snack: 1 unit of insulin per _____grams of carbohydrate

Example: Grams of Carbs in meal ÷ Insulin-to Carb ratio = _____ units of insulin

Correction Dose

Glucose Correction Factor/Insulin Sensitivity Factor = _____
Target glucose = _____mg/dL

Example:
Actual glucose –Target glucose ÷ Glucose Correction Factor/Insulin Sensitivity Factor = _____units of insulin

Correction dose scale (use instead of calculation to determine insulin correction dose)
Glucose _____ to _____mg/dL, give _____ units
Glucose _____ to _____mg/dL, give _____ units
Glucose _____ to _____mg/dL, give _____ units
Glucose _____ to _____mg/dL, give _____ units

When to give insulin:

Lunch
○Carb coverage only
○Carb coverage plus correction dose when glucose is greater than _____mg/dL and _____hours since last insulin dose.
○Other: _____

Snack
○No coverage
○Carb coverage only
○Carb coverage plus correction dose when glucose is greater than _____mg/dL and _____hours since last insulin dose.
○Other: _____

Correction Dose Only
○For glucose is greater than _____mg/dL AND _____hours since last insulin dose.
○Other: _____

Fixed Insulin Therapy

Name of Insulin: _____

○ _____units of insulin given pre-lunch daily
○ _____units of insulin given pre-snack daily
○ Other: _____

Additional Information for student with Insulin Pump

Brand/model of pump: _____ Type of insulin: _____
Basal rates during school: _____
Type of Infusion set: _____

○ For glucose greater than _____mg/dL that has not decreased within _____hours after correction, consider pump failure or infusion site failure. Notify parent/guardian
○ For infusion site failure: Insert new infusion set and/or replace reservoir.
○ For suspected pump failure: suspend or remove pump and give insulin by syring or pen.

Physical Activity

May disconnect from pump for sports activities ○yes ○no
Set a temporary basal rate? ○Yes, _____% temporary basal for ____ hours. ○No
Suspend pump use ○yes ○no

Student's self-care pump skills

Student is independent in:
Counting carbohydrates ○yes ○no
Bolus correct amount for carbs consumed ○yes ○no
Calculate and administer correction bolus ○yes ○no
Calculate and set basal profiles ○yes ○no
Calculate and set temporary basal rate ○yes ○no
Change batteries ○yes ○no
Disconnect pump ○yes ○no
Reconnect pump to infusion set ○yes ○no
Prepare reservoir and tubing ○yes ○no
Insert Infusion set ○yes ○no
Troubleshoot alarms and malfunctions ○yes ○no

Parental Authorization to Adjust Insulin Dose

○ Yes ○ No Parents/guardian authorization should be obtained before administering a correction dose.
○ Yes ○ No Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.
○ Yes ○ No Parents/guardian are authorized to increase or decrease insulin-to-carb ratio within the following range: _____units per prescribed grams of carb, +/- ____ grams of carbs
○ Yes ○ No Parents/guardian are authorized to increase or decrease the fixed insulin dose within the following range: +/- _____units of insulin.

Other Notes: _____
_____
_____

Signatures

This Diabetes Action Plan has been approved by (Student's Physician Signature): _____Date:_____

This plan should be effective from (date): _____ to (date): _____ Emergency Physician Phone: _____

I, (parent/guardian)_____give permission to the school nurse or another qualified health care professional or trained diabetes personnel of Waverly Community Schools to perform and carry out the diabetes care tasks as outlined in (student name)_____'s Diabetes Action Plan. I also consent to the release of information in this Diabetes Action Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified school official to contact my child's physician/health care provider.

Parent/Guardian Signature: _____ Date:_____

Received By:

School Nurse or qualified school official: _____ Date:_____

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Active for School Year: _____

STUDENT MEDICATION REQUEST FORM

This form must be *completed in full and returned with a physician's signature* to current school office before administration of medication can take place within the school. *OTC medications also require a physician's signature.*

Student Name & DOB:	**School & Grade:**
Parent/Guardian:	**Phone:**
Parent/Guardian:	**Phone:**
Name of Prescription or OTC Medication:	
Form of Medication (circle one): Tablet/Capsule Liquid Inhaler Medi-pen Other: _____	
Time to be administered:	
Is this medication for episodic or emergency events only? (circle one): Yes No	
Is the student able to self-carry this medication? (circle one): Yes No	
Possible side effects from medication:	
Health Care Provider Signature: **Printed Name:**	**Phone:**
Preferred Hospital:	**Fax:**
Emergency Contact:	**Phone:**

I give permission for school personnel to share this information, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and equipment devices. I understand and agree that when school personnel administer medication to my child as indicated above, I will not hold the personnel and school district liable in any criminal action or for civil damages. Reference: Act #157, Public Acts of 1971, effective 11/24/1971, Section 378.

All medications must be collected by a parent or guardian within one week of the last day of classes for students. Any medications left after that time will be properly disposed of.

_____

Parent Signature **Date**

School Office Use Only	Administration Office Use Only
Date Received: **Location of Medication:**	**Date Received from Building:** **Date Recorded:**
Reminder: **Scan/Email to School Nurse & Administration Office**	**Reminder:** **Set Alert in PowerSchool, Upload to CEO**