DIABETES ACTION PLAN

Date_____

Student _____ Date of Birth_____ Grade _____

Parent/Guardian (please print)_____Cell Phone _____

Routine Management

Target blood sugar range _____ to _____

Call parent/guardian if values are below _____ or above _____

Required blood sugar testing at school:

❍ Trained personnel must perform blood sugar test
❍ Trained personnel must supervise blood sugar test
❍ Student can perform testing independently

Times to test blood sugar:

❍ Before lunch ❍ Before P.E.
❍ After lunch ❍ After P.E.
❍ As needed for signs/symptoms of low or high blood sugar

Medications to be given during school hours:

❍ Oral diabetes medication(s)/dose _____ Time to be administered _____ To be administered immediately:

❍ Sliding scale:

	Before lunch	After lunch
_____ unit(s) if blood sugar is between _____ and _____	❍	❍
_____ unit(s) if blood sugar is between _____ and _____	❍	❍
_____ unit(s) if blood sugar is between _____ and _____	❍	❍
_____ unit(s) if blood sugar is between _____ and _____	❍	❍

❍ Insulin/carbohydrate ratio _____ unit(s) for every _____ grams of carbohydrates consumed plus _____ units for every _____ mg/dl points above mg/dl

❍ Student can draw up and inject own insulin
❍ Trained adult will draw up and administer insulin
❍ Student is on pump
❍ Glucagon (subcutaneous injection) dosage _____ cc
❍ Student cannot draw up own insulin but can give own injection
❍ Student can draw up but needs adult to inject insulin
❍ Student needs assistance checking insulin dosage

Diet

Lunch time _____ Scheduled P.E. time _____ Recess time _____

Snack Time(s) _____ a.m. _____ p.m. Location where snacks are kept_____ Location eaten _____

❍ Child needs assistance with prescribed meal plan. Parent(s)/guardian(s) and student are responsible for maintaining necessary supplies, snacks, testing kit, medications and equipment.

People trained for blood testing and response:

Name _____ Date _____

Name _____ Date _____

Permission signatures:

As parent(s)/guardian(s) of the student, I give permission for use of this health plan in my student's school and for the school nurse the contact the above providers regarding the above condition. Orders are valid through the end of the current school year.

Parent/guardian signature _____ Date _____

Physician name (please print) _____ Phone _____

Physician signature_____ Date _____