Akron Children's Hospital
SCHOOL HEALTH SERVICES

Diabetes Action Plan
School Year _____

Date _____

Student Name: _____ Date of Birth: _____

School: _____ Grade/Class _____

Parent/Guardian: _____ Phone: _____

Address: _____ Alternate Phone #: _____

Parent/Guardian: _____ Phone: _____

Address: _____ Alternate Phone: _____

Other Emergency Contact: _____
Name Relationship Phone

Primary Physician: _____ Phone: _____

Treating Physician: _____ Phone: _____

Notify parent/guardian or emergency contact in the following situations:

_____

Blood Glucose Monitoring

Target range is _____mg/dl to _____mg/dl.

Blood Glucose levels will be checked before each meal and:
___ Before exercise **___After exercise** **___ Signs and symptoms of hypoglycemia**
___ Signs and symptoms of hyperglycemia

Other: _____

Parents will be contacted if blood sugar is less than 70 or greater than 400

Student can perform own blood glucose tests? ____ Yes ____No Student can carry own supplies ____Yes ____No

Hypoglycemia Treatment (blood sugar < 70)

_____ 2-4 Glucose tablets ____ 4 oz of juice

_____ Glucose gel ____ Other

If no meal or snack within the next hour another 15 gram snack will be given.

Severe Hypoglycemia Treatment

_____ glucose gel
____ Glucagon(SQ in arm or thigh): Dose _____

Hyperglycemia Treatment

____ water ____ Test Ketones if greater than ____

Parents will be notified of Ketone results of moderate and higher. Student will be sent home with moderate ketones and if child is vomiting or too ill to continue in school.

Insulin

Student receives insulin via ____Syringe ____Pen ____Pump
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

Insulin will be given while at school for _____Breakfast _____Lunch

Insulin to Carbohydrate Ratio: _____Unit Insulin for _____Carbohydrates

Correction Factor: _____ Unit Insulin for every _____ above _____ Blood Glucose Level

Physician/Provider Signature:_____

Date: _____ **Phone Number:** _____

Equipment and Supplies (completed by Parent/Guardian)

My Child:
_____ has a glucometer _____ checks own blood sugar _____ needs help checking blood sugar
_____ self - injects insulin _____ needs help with injections _____ has an insulin pump
_____ brings equipment/supplies daily _____ has equipment/supplies stored in clinic

To Be Signed by Parent/Guardian:
I give permission for blood glucose testing by the school health personnel/ nurse using equipment the parent/guardian has provided. I give permission for my child to receive medication (insulin) at school according to the school district policy and as instructed by the physician and agree to:

- Assume responsibility for safe delivery of the medication in its original container to the school
- Notify the school immediately if there is any change in the use of this medication
- Have a new form completed by the doctor if medication or dosage or diabetes management plan is changed
- Notify the school of changes in diabetes management health care provider
- Allow School Health Services staff to send and/or receive information related to my child's health, as they deem appropriate for the duration of this order as noted above

Parent/Guardian: _____ Date: _____