Diabetes Action Plan
Newman International Academy

Student Name: ________________________________________  Grade: ____________  Age: _____

Homeroom Teacher: ____________________________________  Room: _____________________

Parent/Guardian Name: ________________________________  Phone: ______________________

Relationship: ___________________________  Email: ___________________________

Parent/Guardian Name: ________________________________  Phone: ______________________

Relationship: ___________________________  Email: ___________________________

Emergency Phone Contact #1 ____________________________________________________________

Name: ___________________________  Relationship: ___________________________  Phone: __________

Emergency Phone Contact #2 ____________________________________________________________

Name: ___________________________  Relationship: ___________________________  Phone: __________

Physician Treating Student for Diabetes: __________________________________________________

Name: _____________________________________________  Phone: ________________________

BLOOD GLUCOSE MONITORING
Target range for blood Glucose is:  □ 70-150  □ 70-180  □ Other _______________________

Times to check blood glucose (Please check all that apply.)

□ Lunch  □ Before Exercise
□ After Lunch  □ After Exercise
□ Symptoms of Hyperglycemia  □ Symptoms of Hypoglycemia
□ Other: ___________________________________________

Type of blood glucose meter used: ______________________________________________________

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

INSULIN
• Usual Lunchtime Dose
Base dose of Humalog/Novolog/Regular insulin at lunch (circle type of rapid/short acting insulin used) is _____ units or does flexible dosing using _____ units/ _____ grams carbohydrate.
Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente _____ units or basal/Lantus/Ultralente _____ units.
• Insulin Correction Doses
Parental authorization should be obtained before administering a correction dose for high blood glucose levels.
□ Yes  □ No

_____ units if glucose is _____ to _____ mg/dl
_____ units if glucose is _____ to _____ mg/dl
_____ units if glucose is _____ to _____ mg/dl
_____ units if glucose is _____ to _____ mg/dl
_____ units if glucose is _____ to _____ mg/dl

Can student give own injections?  □ Yes  □ No
Can student determine correction amount of insulin?  □ Yes  □ No
Can student draw correct dose of insulin?  □ Yes  □ No
Diabetes Action Plan (Continued)
Newman International Academy

• For Students with Insulin Pumps

Type of pump: ______________________________
Basal rate: _________ 12 am to _________
______ ______ to ______
______ ______ to ______
______ ______ to ______

Type of insulin in pump: ____________________________________________________________
Type of infusion set: ________________________________________________________________
Insulin/carbohydrate ratio: ___________________________________________________________________

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
Troubleshoot alarms and malfunctions □ Yes □ No

MEALS AND SNACKS EATEN AT SCHOOL

Is the student independent in carbohydrate calculations and management? □ Yes □ No

<table>
<thead>
<tr>
<th>Meal/Snack</th>
<th>Time</th>
<th>Food content/amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
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<tr>
<td>Mid-morning snack</td>
<td></td>
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<tr>
<td>Lunch</td>
<td></td>
<td></td>
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<tr>
<td>Mid-afternoon snack</td>
<td></td>
<td></td>
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</tbody>
</table>

Snack before exercise? □ Yes □ No
Snack after exercise? □ Yes □ No
Other times to give snacks and content/amount: ____________________________________________

Preferred snack foods: ________________________________________________________________
Foods to avoid, if any: ________________________________________________________________
Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):
____________________________________________________________________________________

EXERCISE AND SPORTS

A fast-acting carbohydrate such as ______________________________________________________ should be available at the site of exercise or 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.
Diabetes Action Plan (Continued)
Newman International Academy

**BLOOD GLUCOSE AFTERNOON CHECK**

- **Hypoglycemia (Low Blood Sugar)**
  
  Usual symptoms of hypoglycemia: ____________________________________________

  Treatment of hypoglycemia: ________________________________________________

  Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.
  Route ______, Dosage ______, site for glucagon infection: ______ arm, _____ thigh, ______ other.
  If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

- **Hyperglycemia (High Blood Sugar)**
  
  Usual symptoms of hyperglycemia: ________________________________________

  Treatment of hyperglycemia: ____________________________________________

  Urine should be checked for ketones when blood glucose are above ______ mg/dl.
  Treatment for ketones: __________________________________________

**SUPPLIES TO BE KEPT AT SCHOOL**

- _________ Blood glucose meter, blood glucose test strips, batteries for meter.
- _________ Lancet device, lancets, gloves, etc.
- _________ Urine ketone strips
- _________ Insulin vials and syringes
- _________ Insulin pump and supplies
- _________ Insulin pen, pen needles, insulin tube
- _________ Fast-acting source of glucose
- _________ Carbohydrate containing snack
- _________ Glucagon emergency kit

**REQUIRED SIGNATURE**

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Diabetes Action Plan for my child for the ______-______ school year.

___________________________  ________________________
Parent/Guardian                 Date

___________________________  ________________________
School Nurse                   Date