## GREAT HEARTS ACADEMY - DIABETES ACTION PLAN for the 2019-2020 SCHOOL YEAR

FIRST NAME:	FIRST NAME:			
BEST CONTACT PHONE NUMBER:		DOB:		
ENDOCRINOLOGIST NAME:         ENDOCRINOLOGIST PHONE NUMBER:         TEACHER:	PARENT/GUARDIAN:			
ENDOCRINOLOGIST PHONE NUMBER:	BEST CONTACT PHONE NUMB	ER:		
TEACHER:	ENDOCRINOLOGIST NAME:			
Blood sugar testing device:         Blood sugar testing to be done at (time):         Blood sugar testing to be done at (time):         Stood sugar testing to be done by:	ENDOCRINOLOGIST PHONE NU	JMBER:		
Blood sugar testing device:         Blood sugar testing to be done at (time):         Blood sugar testing to be done at (time):         Stood sugar testing to be done by:	TEACHER:	SECTION		
Blood sugar testing to be done at (time):				
Blood sugar testing to be done by:school nurseAfter meals:After meals:				
Target blood sugar range before meals:				
Parent/guardian will be notified if target range not met in three consecutive blood sugar testsyes no           INSULIN TO BE GIVEN AT SCHOOL:	Blood sugar testing to be done	by: school nurse self-test by s	tudent with stand	-by assistance provided by nurse
INSULIN TO BE GIVEN AT SCHOOL:       TIME:       DOSE:         Administration method:				ves po
Insulin to be given at school by: school nurse self-administer by student with stand-by assistance provided by nu Carbohydrate counting ratio: Number of carbohydrate grams to number of insulin units Insulin pump dosing specifics: ORAL diabetes medication to be given at school: Medication: Dose: TIME: HYPOGLYCEMIA PROTOCOL: (Symptoms of low blood sugar include hunger, irritability, shakiness, sleepiness, sweating, uncooperative or other specific symptoms displayed by my child: If blood sugar below then give Recheck blood sugar after minutes and if blood sugar below then repeat above treatment SEVERE HYPOGLYCEMIA: (Child unable to swallow/absorb hypoglycemia treatment or loss of consciousness) 1. Note time and occurrence of symptoms and stay with student 2. Blood sugar test below 3. Call 9-1-1 4. Give the following Injection: Given to nurseyes date Dose: Other instructions:			noou sugar tests _	yes no
Insulin to be given at school by: school nurse self-administer by student with stand-by assistance provided by nu Carbohydrate counting ratio: Number of carbohydrate grams to number of insulin units Insulin pump dosing specifics: ORAL diabetes medication to be given at school: Medication: Dose: TIME: HYPOGLYCEMIA PROTOCOL: (Symptoms of low blood sugar include hunger, irritability, shakiness, sleepiness, sweating, uncooperative or other specific symptoms displayed by my child: If blood sugar below then give Recheck blood sugar after minutes and if blood sugar below then repeat above treatment SEVERE HYPOGLYCEMIA: (Child unable to swallow/absorb hypoglycemia treatment or loss of consciousness) 1. Note time and occurrence of symptoms and stay with student 2. Blood sugar test below 3. Call 9-1-1 4. Give the following Injection: Given to nurseyes date Dose: Other instructions:	INSULIN TO BE GIVEN AT	SCHOOL:	TIME:	DOSE:
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Carbohydrate counting ratio: Number of carbohydrate grams to number of insulin units Insulin pump dosing specifics: ORAL diabetes medication to be given at school: Medication: Dose: TIME: HYPOGLYCEMIA PROTOCOL: (Symptoms of low blood sugar include hunger, irritability, shakiness, sleepiness, sweating, uncooperative or other specific symptoms displayed by my child: If blood sugar below then give Recheck blood sugar after minutes and if blood sugar below then repeat above treatment SEVERE HYPOGLYCEMIA: (Child unable to swallow/absorb hypoglycemia treatment or loss of consciousness) 1. Note time and occurrence of symptoms and stay with student 2. Blood sugar test below 3. Call 9-1-1 4. Give the following Injection: Given to nurseyes date Dose: Other instructions:				
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SEVERE HYPOGLYCEMIA: (Child unable to swallow/absorb hypoglycemia treatment or loss of consciousness)         1. Note time and occurrence of symptoms and stay with student         2. Blood sugar test below	Medication:	<b>COL</b> : (Symptoms of low blood sugar include hum	nger, irritability, sh	akiness, sleepiness, sweating,
<ol> <li>Note time and occurrence of symptoms and stay with student</li> <li>Blood sugar test below</li> <li>Call 9-1-1</li> <li>Give the following Injection: Given to nurseyes date</li> <li>Dose:</li> <li>Other instructions:</li> </ol>	Medication:	Dose COL: (Symptoms of low blood sugar include hun symptoms displayed by my child:	nger, irritability, sh	akiness, sleepiness, sweating,
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<ol> <li>Blood sugar test below</li> <li>Call 9-1-1</li> <li>Give the following Injection: Given to nurseyes date</li> <li>Dose:</li> <li>Other instructions:</li> </ol>	Medication: HYPOGLYCEMIA PROTO uncooperative or other specific	COL: (Symptoms of low blood sugar include hunger symptoms displayed by my child:	nger, irritability, sh	akiness, sleepiness, sweating,
<ul> <li>3. Call 9-1-1</li> <li>4. Give the following Injection: Given to nurseyes date</li> <li>Dose:</li> <li>Other instructions:</li> </ul>	Medication:	COL: (Symptoms of low blood sugar include hum s symptoms displayed by my child:	ger, irritability, sh	akiness, sleepiness, sweating,
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Other instructions:	Medication:	COL: (Symptoms of low blood sugar include hung symptoms displayed by my child:	nger, irritability, sh	repeat above treatment ss of consciousness)
	Medication:	COL: (Symptoms of low blood sugar include hum symptoms displayed by my child:	nger, irritability, sh	repeat above treatment ss of consciousness)
	Medication:	COL: (Symptoms of low blood sugar include hunder symptoms displayed by my child:	nger, irritability, sh	repeat above treatment ss of consciousness)
	Medication:	COL: (Symptoms of low blood sugar include hunder symptoms displayed by my child:	nger, irritability, sh	repeat above treatment <i>ss of consciousness)</i>
HYPERGLYCEMIA PROTOCOL: (Symptoms of high blood sugar include extreme thirst, increased frequency of urination,	Medication:	COL: (Symptoms of low blood sugar include hunder symptoms displayed by my child:	nger, irritability, sh	repeat above treatment <i>ss of consciousness)</i>
headache, flushing, irritability, loss of appetite, fatigue, or other specific symptoms displayed by my child:	Medication:	COL: (Symptoms of low blood sugar include hund symptoms displayed by my child:	nger, irritability, sh	repeat above treatment ss of consciousness) ven to nurseyes date
1. Blood sugar test above	Medication:	COL: (Symptoms of low blood sugar include hum symptoms displayed by my child:	nger, irritability, sh	akiness, sleepiness, sweating, repeat above treatment ss of consciousness) ven to nurseyesdate vait EMS.
T. Plood angai rear anove	Medication:	COL: (Symptoms of low blood sugar include humes symptoms displayed by my child:	nger, irritability, sh	akiness, sleepiness, sweating, repeat above treatment ss of consciousness) ven to nurseyesdate vait EMS.
2. Correction does formula for high blood sugary (use the head of form if recovery)	Medication:	COL: (Symptoms of low blood sugar include hund symptoms displayed by my child:	oger, irritability, sh	akiness, sleepiness, sweating, repeat above treatment ss of consciousness) ven to nurseyes date vait EMS. rreased frequency of urination, my child:
2. Correction dose formula for high blood sugar: (use the back of form if necessary)	Medication:	COL: (Symptoms of low blood sugar include hund symptoms displayed by my child:	oger, irritability, sh	akiness, sleepiness, sweating, repeat above treatment ss of consciousness) ven to nurseyes date vait EMS. rreased frequency of urination, my child:

I understand that school staff MUST be informed of my child's health concerns in order to provide safe and appropriate care. I will update the school nurse office as my child's health conditions/treatments change throughout the year.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_