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

CHILD **LAST** NAME: ____
FIRST NAME: ________________________________ DOB:___________
PARENT/GUARDIAN: ____
BEST CONTACT PHONE NUMBER: ________________________________
ENDOCRINOLOGIST NAME: ____________________________________
ENDOCRINOLOGIST PHONE NUMBER: _____________________________
TEACHER: ___________________________ SECTION ________________

☐ Blood sugar testing device: _________________________________
Blood sugar testing to be done at (time): ___________________________
Blood sugar testing to be done by: ______ school nurse _______ self-test by student with stand-by assistance provided by nurse
Target blood sugar range before meals: _______________ After meals: _______________
Parent/guardian will be notified if target range not met in three consecutive blood sugar tests _____ yes _____ no

☐ **INSULIN** TO BE GIVEN AT SCHOOL: _______________________________ TIME: ____________DOSE: ________________
Administration method: ____________ syringe ____________ pump ____________ insulin pen

Insulin to be given at school by: ______ school nurse _______ self-administer by student with stand-by assistance provided by nurse
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 nurse ____yes ____ date
   Dose: ____
   Other instructions: ________________________________
5. Call Parent. Repeat dose if symptoms worsen or child becomes unresponsive. Await EMS.

☐ **HYPERGLYCEMIA PROTOCOL**: *(Symptoms of high blood sugar include extreme thirst, increased frequency of urination, headache, flushing, irritability, loss of appetite, fatigue, or other specific symptoms displayed by my child:_____________________)*

1. Blood sugar test above _____________________
2. Correction dose formula for high blood sugar: *(use the back of form if necessary)* ______________________________
   ____

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: _____________