

GREAT HEARTS ACADEMY – DIABETES ACTION PLAN for the 2020-2021 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: _____