

**GREAT HEARTS ACADEMY – DIABETES ACTION PLAN** for the 2022-2023 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: \_\_\_\_\_