

DIABETES INFORMATION ACTION PLAN
Health Services
Lincoln Public Schools

INFORMATION FOR PARENTS/GUARDIANS: This action plan should be completed and signed and returned to the school health office. Information should be updated in writing as frequently as necessary. Information will be shared with the appropriate school personnel to promote your child's safety and educational success at school. Your signature is required for medication and treatment consent. Written authorization for medically necessary cares from your physician is also required. Please contact the school nurse for more information.

Student Name: _____ ID#: _____ Grade: _____

Date of Birth: _____ Today's Date: _____ Homeroom Teacher: _____

Date of Diabetes Diagnosis: _____ Diabetes Type I Diabetes Type II

Person Completing this form: _____ Relationship to Student: _____

CONTACT INFORMATION

<p>Parent/Guardian #1</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____</p>	<p>Parent/Guardian #2</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____</p>
<p>Emergency Contact #1</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____ Relationship: _____</p>	<p>Emergency Contact #2</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____ Relationship: _____</p>
<p>Your Child's Diabetes Doctor:</p> <p>Name: _____</p> <p>Clinic Group: _____</p> <p>Phone: _____</p>	<p>Hospital Preference: (We cannot guarantee where your child will be taken in the event of an emergency):</p> <p>_____</p>

HYPOGLYCEMIA MANAGEMENT (Low Blood Sugar)

Usual Signs of Hypoglycemia: _____

Treatment of Hypoglycemia (specify blood sugar ranges as needed):

Glucagon is to be Administered Under the Following Circumstances:

Note: If glucagon is administered, 911 and parents/guardian will be summoned to the school.

HYPERGLYCEMIA MANAGEMENT (High Blood Sugar)

Usual signs of Hyperglycemia: _____

Treatment of Hyperglycemia (specify blood sugar ranges as needed):

Urine Should be Checked for Ketones When Blood Glucose Levels are Above _____ mg/dl.

Completed by: _____ Date: _____

BLOOD GLUCOSE MONITORING

Target Range: _____

Preferred Anatomical Site(s) for Taking Sample (finger, forearm, rotation schedule): _____

Preferred School Location for Performing Blood Glucose Tests: _____

Type of Glucometer Used by Student: _____

EXERCISE AND SPORTS

Parent/Guardian Will Provide a Fast-Acting Carbohydrate Such as _____ to PE Teacher or Coach.

Restrictions on Activity, if Any: _____

Student Should Not Exercise if Blood Glucose is Below _____ mg/dl or if Moderate to Large Ketones are Present at School (if tested).

MEALS AND SNACKS AT SCHOOL

Snack Foods or Fast-Acting Carbohydrate Such as _____ are Provided by the Parent/Guardian.

Location: _____

Instructions When Food is Provided to the Class (e.g. as part of a class party or food sampling event):

Instructions for Field Trips: _____

Student Will Carry a Fast-Acting Carbohydrate Such as _____ for Self-Administration.

ORAL MEDICATIONS

Name of Medication: _____ Dose: _____ Time: _____

Name of Medication: _____ Dose: _____ Time: _____

INSULIN PUMP USERS (See page 4 for daily insulin orders)

Type of Pump: _____ Type of Insulin in Pump: _____

Type of Infusion Set: _____ Maximum Bolus Setting: _____

How Long Has Your student Had an Insulin Pump: _____

Parents/Guardians: by Signing Below You Acknowledge the Following:

- You are providing your written consent to provide treatments to your student as described.
- You are providing your written consent to administer medications as described.
- If needed, the prescribing physician may be contacted by the school nurse for clarification on medication administration.
- Your written consent will be needed in order to change medication or treatment orders on your child. You must provide changes in writing with your signature.
- The information provided in the diabetes information and action plan may be shared with other school staff to promote your child's safety and educational success at school.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Parents/Guardians please use these checklists to help make certain we are prepared to care for your student.

STUDENT SKILL ASSESSMENT

Check all that student is able to perform reliably and independently (WITHOUT assistance or supervision):

- Count Carbohydrates
- Perform Own Blood Glucose Checks
- Check Urine for Ketones
- Calculate Corrective Dose of Insulin Based on Carbs or Blood Glucose
- Draw up Insulin or Set Insulin Dose Device (pen)
- Self-Administer Insulin by Injection

Insulin-Pump Users Only

- Bolus Correct Amount on Pump for Carbohydrates Consumed
- Calculate and Set Temporary Basal Rate on Pump
- Disconnect Pump
- Reconnect Pump at Infusion Set
- Prepare Reservoir and Tubing on Pump
- Insert Infusion Set for Pump
- Troubleshoot Alarms and Malfunctions on Pump
- Check Urine for Ketones

PROVIDED BY PARENT/GUARDIAN

- Glucometer, Test Strips Lancets, Control Solution
- Urine Ketone Strips
- Insulin Vials and Syringes
- Insulin pump and Supplies
- Insulin Pen, Pen Needles, Insulin Cartridges
- Oral medications (specify _____)
- Fast acting glucose (specify _____)
- Snacks (specify _____)
- Glucagon Emergency Kit
- Physician Authorization for Meds Including Glucose and Insulin
- Physician Authorization for Procedures Including Blood Glucose Monitoring
- Completed and Signed Diabetes Information Action Card

Person Completing this Form:

Completed By: _____ Date: _____

DIABETES MEDICAL MANAGEMENT PLAN

**May be updated as often as needed.
Changes require parent signature and school nurse verification.**

Time	Glucose Testing	Snack or Meal	Insulin Type and Dose	Start Date	SN Initial & Date When Verified

Insulin Correction for Blood Glucose Reading:

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

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

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

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

Adjust Insulin Dose to Carbohydrate Intake Using _____ Units per _____ Grams Carbohydrate.

Maximum Bolus Dose _____ Units.

Parent/Guardian Signature (or medical authorization) Required for Dose Changes:

Parent/Guardian Signature: _____ Date: _____