DIABETES ACTION PLAN

Date of Plan: ___/___/____ Effective dates: ___/___/____

Student Name: _____ Date of Birth: ___/___/____

School: _____ Grade: _____ Homeroom teacher:_____

Contact Information:

Guardian #1: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Guardian #2: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Emergency Contact: _____

Phone: Home: _____ Work: _____ Cell: _____

Health Care Provider: _____

Phone: _____ Emergency # _____

Blood Sugar Monitoring:

Target range for blood sugar: _____

Can student perform own blood sugar checks: _____

Daily blood sugar schedule: _____

Additional blood sugar checks: (check all that apply) Before exercise _____

After exercise _____ Other (explain) _____

Low blood sugars:

If **blood sugar below 70: Repeat in 15 minutes.**
Treat with fast acting carbohydrate 15-20 grams CHO (3 or 4 glucose tabs (4-5 gms each)
Fruit juice or regular soda ½ cup)

Watch student and repeat if needed. Document and inform parents. If unconscious/seizure: Call 911. Do not give food.

Glucagon: Dose_____Indications_____

High blood sugars:

If blood sugar over _____, check urine for ketones.

Insulin administration while at school:

Can student give own injections? _____ Can student determine correct amount of insulin? _____

Can student draw correct amount of insulin?_____

Insulin type:_____ Dose: _____ Time:_____

Insulin to carbohydrate ration is 1 unit of_____ for every _____ grams of carbohydrates.

Correction/Sensitivity factor for treatment of High Blood _____**or**

Insulin correction doses for high blood sugars:

_____ units if blood sugar is ____ to _____ mg/dl.
_____ units if blood sugar is ____ to _____ mg/dl.
_____ units if blood sugar is ____ to _____ mg/dl.
_____ units if blood sugar is ____ to _____ mg/dl.

Insulin pump administration:

Pump type _____ Type of insulin in pump:_____

Is student independent with the following pump skills? _____

Count carbs and give correct bolus for carbs consumed _____

Calculate and administer correction bolus _____ Disconnect Pump _____

Reconnect pump at infusion set _____ Fill reservoir and prime tubing _____

Insert new infusion set _____Trouble shoot all alarms _____

Snacks:

Morning _____ amount _____ Afternoon _____ amount _____

Additional Comments: _____

_____

_____

Healthcare practitioner signature and date:_____

Parent signature and date: _____