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: _____