Diabetes Action Plan

Signs of low blood sugar (<mg (<mg="" (please="" a="" becomes="" blood="" child="" circle)<="" coma,="" confusion,="" crying,="" dl):="" drowsiness,="" fatigue,="" for="" give="" glucagon:="" glucagoomg="" has="" headedness,="" hyperactivity="" if="" irritability,="" light="" low="" no="" or="" pallor,="" restlessness="" scizure="" seizure="" shakiness,="" subcutaneously.="" sugar="" sweating,="" th="" treatment="" tremors,="" uncoactclous="" yes=""><th>Target blood glucose</th><th>nsulin: carbohydrate ratio/range</th><th>Correction factor</th></mg>	Target blood glucose	nsulin: carbohydrate ratio/range	Correction factor
GLUCAGON: If a child becomes unconcacious or has a seizure give glucagos mg subcutaneously. Yes No (Please circle) *Cal 911 and Parents/Guardian *Do not force eating or drinking. Turn on side. Signs of high blood sugar (> mg/dl): thirst, frequent urination, headache, fatigue Treatment for high blood sugar (> mg/dl)_	Signs of low blood sugar (< drowsiness, seizure or coma, res	_mg/dl): irritability, tremors, swe tlessness/hyperactivity	ating, fatigue, shakiness, pallor, crying, light headedness, confusion,
GLUCAGON: If a child becomes unconscious or has a selzure give glucagoamg subcutaneously. Yes No (Please circle) "Call 911 and Parents/Guardian "Do not force eating or drinking. Turn on side. Signs of high blood sugar (>mg/dl): thirst, frequent urination, headache, fatigue Treatment for high blood sugar (>mg/dl)	Freatment for low blood sugar (<	mg/dl):	
Call 911 and Parents/Caurdian **Do not force eating or drinking. Turn on side. Signs of high blood sugar (>mg/dl): thirst, frequent urination, headache, fatigue Treatment for high blood sugar (>mg/dl). (indicate those that apply: insulin, water, exercise yes/no, check for ketones, etc.) Child is able to: Child is able to: Child is able to: Child is able to: Blood Glucose Monitoring Times (Check all that apply) Test own glucose Yes / No Before exercise Determine insulin dose Yes / No After exercise Determine insulin dose Yes / No Before a.m. snack Administer insulin dose Yes / No Managa and troubleshoot pump Yes / No Managa and troubleshoot pump Yes / No If signs of low or high blood sugar other Insulin Injections: Insulin Pump: (if applicable) Meals/Snacks at school Time Type of pump Time Type of pump Time Type of insulin Banal rate and time(s) Lucch Lucch P.M. Saack Exercise and Sports Student should not exercise Yes / No Snack before exercise Yes / No Snack safter exercise Yes / No S	Fifteen minutes after treatment if	blood sugar is (<mg d):<="" td=""><td></td></mg>	
Treatment for high blood sugar (>mg/dl) (indicate those that apply: insulin, water, exercise yes/no, check for ketones, etc.) Child is able to:	*Call 911 and Parents/Guardian		ve glucagon mg subcutaneously. Yes No (Please circle)
Child is able to: Child is able to: Check all that apply) Determine insulin dose Yes / No Before exercise Determine insulin dose Yes / No Before exercise Determine insulin dose Yes / No Before a.m. snack Administer insulin dose Yes / No Before lunch Bef	Signs of high blood sugar (>	_mg/dl): thirst, frequent urination	, headache, fatigue
Child is able to: Blood Glucose Monitoring Times (Check all that apply)	Treatment for high blood sugar	(> mg/dl)	or ketones etc.)
Child is able to: (Check all that apply) Before exercise Determine insulin dose Yes / No After exercise Determine insulin dose Yes / No After exercise Determine insulin dose Yes / No Before exercise Before exercise Before exercise Defore insulin dose Yes / No Before exercise Before exercise Defore insulin dose Yes / No Before exercise Defore lunch before p.m. snack Administer insulin dose Yes / No Before p.m. snack Lif signs of low or high blood sugar other Insulin Pump: (If applicable) Meals/Snacks at school Type of pump Time Type of pump Time Type of insulin Basal rate and time(s) A.M. Snack Lunch P.M. Correction Factor Exercise and Sports Student should not exercise if blood glucose is <md dl="" or="">mg/dl Snack before exercise Yes / No Instructions for food in class, e.g. party Supplies to be provided by parents: Blood Glucose Monitor and all monitoring supplies, Insulin and administration supplies. I hereby certify that the above information is complete and will allow for the proper care and monitoring of my child/patient while at school and that I have provided the school with all information that I have, in writing, that they will need to reasonably care for and monitor my child's health related to his/her diabetic condition. I hearby certify that my child can monitor and manage his/her care without supervision from school personnel except in emergencies. Ignature and dates:</md>	(indicate those that apply: insun	II, Water, exercise yes ito, effect in	
Check all that apply) Betore exercise Determine insulin dose Yes / No After exercise Draw up insulin Yes / No Before exercise Draw up insulin dose Yes / No Before a.m. snack Administer insulin dose Yes / No Before p.m. snack Defore p.m. snack Child/parent will manage Yes / No If signs of low or high blood sugar other Type(s) of lasulin Dosage Type of pump Time Type(s) of lasulin Type of insulin Beasir rate and dime(s) Insulin/Carbobydrate ration: Exercise and Sports Student should not exercise if blood glucose is <md dl="" or="">mg/dl Snack after exercise Yes / No Snack after exercise Yes / No Insulin of code in class, e.g. party Supplies to be provided by parents: Blood Glucose Monitor and all monitoring supplies, Insulin and administration supplies. I hereby certify that the above information is complete and will allow for the proper care and monitoring of my child/patient while at school and that I have provided the school with all information that I have, in writing, that they will need to reasonably care for and monitor my child's health related to his/her diabetic condition. I hearby certify that my child can monitor and manage his/her care without supervision from school personnel except in emergencies. Ignature and dates:</md>	CONTRACT CONTRACT	Pland Cluss	
Test own glucose	Child is able to:		Se treated the same
Determine insulin dose Yes / No Before a.m. snack Administer insulin dose Yes / No Before lunch before lunch before p.m. snack Administer insulin dose Yes / No Before lunch before p.m. snack If signs of low or high blood sugar other Insulin Injections: Insulin Pump: (if applicable) Type of pump Time Type of pump Type of insulin Breakfast Basal rate and time(s) Insulin/Correction Factor Exercise and Sports Student should not exercise if blood glucose is <md dl="" or="">mg/dl Snack before exercise Yes / No Snack after exercise Yes / No Snack after exercise Yes / No Snack after exercise Yes / No Snack for food in class, e.g. party Supplies to be provided by parents: Blood Glucose Monitor and all monitoring supplies, Insulin and administration supplies. I hereby certify that the above information is complete and will allow for the proper care and monitoring of my child/patient while at school and that I have provided the school with all information that I have, in writing, that they will need to reasonably care for and monitor my child's health related to his/her diabetic condition. I hearby certify that my child can monitor and manage his/her care without supervision from school personnel except in emergencies. Ignature and dates:</md>	Fest own plucose	Yes / No Bo	efore exercise
Draw up insulin	B	Ves / No A	fter exercise
Administer insulin dose Yes / No Before junch Manage and troubleshoot pump Yes / No before p.m. snack If signs of low or high blood sugar other Insulin Injections:		Ves / No Bo	efore a.m. snack
Analge and doubleshoot pump Yes / No of Strings of low or high blood sugar other oth		Ves / No B	-fore lunch
Insulin Injections: Ime	formers and troubleshoot nump	Ves / No be	fore p.m. snack
Insulin Injections: Insulin Pump: (if applicable) Meals/Snacks at school	Thild/secont will manage	Vec / No	signs of low or high blood sugar
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