Diabetes Action Plan

Student's Name _____ School _____ Physician _____ Effective Date _____

Target blood glucose _____ **Insulin: carbohydrate ratio/range** _____ **Correction factor** _____

Signs of low blood sugar (<_____mg/dl): irritability, tremors, sweating, fatigue, shakiness, pallor, crying, light headedness, confusion, drowsiness, seizure or coma, restlessness/hyperactivity

Treatment for low blood sugar (<_____mg/dl): _____

Fifteen minutes after treatment if blood sugar is (<___mg/d): _____

GLUCAGON: If a child becomes unconscious or has a seizure give glucagon _____ **mg 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)_____
(indicate those that apply: insulin, water, exercise yes/no, check for ketones, etc.)

Child is able to:

Test own glucose	Yes / No
Determine insulin dose	Yes / No
Draw up insulin	Yes / No
Administer insulin dose	Yes / No
Manage and troubleshoot pump	Yes / No
Child/parent will manage	Yes / No

Blood Glucose Monitoring Times
(Check all that apply)

_____ Before exercise
_____ After exercise
_____ Before a.m. snack
_____ Before lunch
_____ before p.m. snack
_____ If signs of low or high blood sugar
_____ other

Location where monitoring will take place:

_____

Insulin Injections:

Time	Type(s) of Insulin	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Insulin Pump: (if applicable)

Type of pump _____
Type of insulin _____
Basal rate and time(s) _____
Insulin/Carbohydrate ration: _____
Correction Factor _____

Meals/Snacks at school

Time
Breakfast _____
A.M. Snack _____
Lunch _____
P.M. Snack _____

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
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. Glucagon emergency kit (if ordered), snack foods, fast acting glucose source, Ketone testing 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.

Signature and dates:

Parents _____ Student _____ Date _____

Physician _____ Date _____ School Representative and Title _____