DIABETES ACTION PLAN

Student's Name: ______________________________ **Date of Birth:** ________________
Grade: ________________ **Home Room Teacher:** ______________________________

Location of supplies: Blood glucose monitor ________________ Insulin supplies ________________
Snack foods ____

Blood Glucose Monitoring
Contact parent if blood glucose is less than ____________ **or greater than** ____________.
Student can perform own blood glucose checks without supervision. _____Yes _____No
Times to check blood glucose *(check all that apply):*

______ with symptoms of hypoglycemia – low blood sugar - (shaky, sweaty, confused)
______ with symptoms of hyperglycemia - high blood sugar - (thirsty, frequent urination)
______ before lunch, __________(time)
______ before/after exercise
______ other, please specify ____

Usual symptoms of low blood sugar ____
****EMERGENCY**Low Blood Sugar – (Hypoglycemia) treatment** – *(check all that apply):*

______ 2-4 glucose tablets
______ 4 oz of juice, __________(type)
______ glucose gel (using finger place between cheek & gum in mouth) ½ tube
______ other, please specify ____
____

It is parent's responsibility to provide the school with low blood sugar treatment snacks to have available at all times!!

Usual symptoms of high blood sugar ____
High Blood Sugar – (Hyperglycemia) treatment ____
Insulin – *(Check all that apply):*

______ Student not taking insulin at school
______ Student takes insulin at school

______ SC Insulin	______ Humalog
______ Insulin via insulin pump	______ Novolog
______ Insulin with lunch	______ Humulin R
______ Insulin with snack	______ Other, ____________________(type)

______ Student may give own sc injections with supervision
______ Student using an insulin pump and may give own boluses
______ Give _______ units of Humalog/Novalog/Humulin R SQ if glucose is > ________.
______ Give insulin according to current scale for elevated blood glucose; confirm dose with parent.
______ Student may determine correct dose of insulin
______ School to administer insulin

Snacks – *(Check all that apply):*

Please allow a ______ gram snack at ______am
Please allow a ______ gram snack at ______pm
Please allow a ______ gram snack prior to gym class
Please allow a ______ gram snack at __________

Instructions for when food is provided to the class, such as part of a class party or food sampling:
____

Special Instructions: ____
____
____

Physician's Signature (required)	**Physician's Printed Name**	**Date**

Physician's Address	**Physician's Phone Number**

I authorize school personnel to implement this management and emergency plan as described above.

Parent/Guardian Signature	**Date**