Must be completed by a **Licensed Health Professional**

Spencer County Public Schools Health Services

DIABETES ACTION CARE PLAN

PRINT Student Name: ______________________________ School Year ______________

Date of Birth: ______________________________ Teacher/Grade ____________

Date of Diagnosis: ______________________________ Bus Route ________________

Emergency Contacts:

Name(s) 1)________________________ 2)_________________________ 3) _________________________

Phone # for 1) ______________________ for 2) _______________________ for 3) ________________________

PRINT Treating Physician **Name**:______________________ **FAX** _________________ **Ph.#** __________________

Student's Self-Management Skills	**NEEDS** Supervision/Assistance	**DOES NOT NEED** Supervision/Assistance
Performs and Interprets Blood Glucose Tests		
Calculates Carbohydrate Grams		
Determines Correction Dose of Insulin for High Blood Glucose		
Determines Insulin Dose for Carbohydrate Intake		
Administers Insulin by pump or injection		
Troubleshoots alarms and malfunctions if using insulin pump		
Disconnects/Reconnects pump if needed		
Calculates dosages and administers insulin **WITHOUT** supervision:	**YES**	**NO**

Insulin Administration

Type of Insulin at school:	____Regular	___Humalog	____Novolog	____Apidra	____N P H	____Lantus	____Levemir	____Other
Insulin Delivery:	____Syringe	____Pen	____ Pump: **# of years on a pump: _____**					

LOW Blood Sugar (HYPO-glycemia) - Test Blood Sugar to Confirm

Signs and Symptoms (may include any of the following):

Does the student recognize signs of **LOW** blood sugar? ____YES ____NO

LOW BLOOD SUGAR:	Hungry	Weak/Shaky/Pale	Headache	Dizziness	Inattention/Confusion	
VERY LOW BLOOD SUGAR:	Nausea or loss of appetite	Slurred Speech	Clamminess or sweating	Blurred Vision	Loss of Consciousness	Other _____________

Management of Low Blood Glucose (below _____mg/dl)

If student is awake and able to swallow:

1. Give 15 grams of simple carbohydrate
   a) i.e. 4 ounces of juice, 4 sugar packets, 4 ounces of a regular soft drink (Not Diet), 15 skittles, OR 4 glucose tablets
2. Re-test blood glucose in 15 minutes, if remains less than 70 mg/dL, repeat the 15 gram simple carbohydrate.
3. Continue the 15 grams of simple carbohydrate snack every 15 minutes until blood glucose level rises above 70 mg/dL.
4. Once blood glucose rises above 70 mg/dL, give a 15 gram complex carbohydrate and protein snack *
   a) i.e. 3 graham cracker squares, 6 saltine crackers, or a half of a sandwich. Peanut butter or cheese should be added to the crackers if available.
   b) If a meal or snack is already scheduled within 30 minutes, give scheduled meal/snack (administering the **insulin after the food** is consumed).
5. Notify Parent when blood glucose is below 70 mg/dL after 2 treatments.
6. Delay exercise and exams if blood glucose is below 90 mg/dL.

If student is unconscious or having a seizure, call 911 immediately and notify parents. Position student on side if possible. If wearing an insulin pump, place pump in suspend/loop mode or disconnect/cut tubing.

If student is **transferred via EMS, an adult must accompany the student.**

Glucagon: 1 mg administered into the muscular area of the upper arm or leg by trained personnel.

Print Student's Name ________________________________

HIGH Blood Sugar (HYPER-glycemia) - Test Blood Sugar to Confirm

SIGNS & SYMPTOMS: (May include any of the following):
Does the student recognize signs of HIGH blood sugar? ___ YES ___NO

High Blood Sugar:	Increased thirst and/or urination	Tired/drowsy	Blurred Vision	Warm, dry or flushed skin	Weakness/muscle aches
Very High Blood Sugar:	Nausea/Vomiting	Abdominal Pain	Extreme Thirst	Fruity breath odor	Other

Management of High Blood Glucose (Over ______ mg/dL)

1. Encourage extra liquids without sugar. Do **NOT** give milk or juice.
2. Allow frequent trips to the restroom.
3. Check ketones if blood glucose over 250 mg/dl x 2 episodes.
4. Notify parents if ketones positive.
5. Do NOT participate in PE or sports if ketones are present.
6. Delay exercise and exams if blood glucose is above ______ mg/dl.
7. Refer to the Correction Dose section below
8. Student does NOT need to be sent home unless vomiting or other acute illness.
9. Retest blood glucose in 1 hour.

High Blood Sugar Correction Dose

The student's target Blood Glucose range is _______ to _______.

☐ **Use Insulin Correction Dose Formula**

Determine insulin correction dose per correction formula below:

If BG > _______ mg/dL, give _______ unit per _______ mg/dL > _______ mg/dL

(i.e. BG — _______ / _______ = correction dose)

☐ **Use Ketone Supplementation Formula**

Check urine for ketones when blood glucose is ≥ 250 mg/dl or when student is ill.

Give additional insulin as follows: Small = _______ units; Moderate = _______ units; Large = _______ units

** **NOTE:** Do **NOT** correct for Ketones more often than every **4 hours.** **

Blood Glucose Testing (check what applies)		Insulin Dosage for based on Carb Count	
Test Blood	**Give Correction?**	**Give insulin (r/t food)**	**Insulin Dose or Carb Formula**
☐ Before Breakfast	☐ Y N ☐	☐ Before After ☐	One unit of insulin per _______ grams of carbs
☐ Before Morning Snack	☐ Y N ☐	☐ Before After ☐	One unit of insulin per _______ grams of carbs
☐ Before Lunch	☐ Y N ☐	☐ Before After ☐	One unit of insulin per _______ grams of carbs
☐ Before Afternoon Snack	☐ Y N ☐	☐ Before After ☐	One unit of insulin per _______ grams of carbs
☐ Before PE/Activity	☐ Y N ☐	☐ Before After ☐	One unit of insulin per _______ grams of carbs
☐ After PE / Activity	☐ Y N ☐	☐ Before After ☐	One unit of insulin per _______ grams of carbs
☐ Dismissal	☐ Y N ☐	☐ Before After ☐	One unit of insulin per _______ grams of carbs

☐ As needed for signs/symptoms.

DO NOT give a correction dose if within 3 hours of the last bolus or injection.

Additional comments (Pump orders):

I understand that all treatments and procedures may be performed by the student and/or authorized trained school personnel. I also understand that the school is not responsible for damage/loss of equipment. **Snacks and supplies are to be furnished/restocked by parent.**

PARENT'S Signature ______________________________ Printed Name ________________________ Date ____________

PHYSICIAN Signature ______________________________ Printed Name ________________________ Date ____________

SCHOOL NURSE Signature ___________________________ Printed Name ________________________ Date____________