ST. PIUS X REGIONAL SCHOOL
14710 ANNAPOLIS ROAD, BOWIE, MD 20715-1813
Phone 301-262-0203 Fax 301-805-8875

DIABETES ACTION PLAN for School Year _____ to _____

To be Completed by Parent/Guardian:

Full Name of Student_____**Classroom/Grade** _____

- ❑ I understand that I must supply the School with the Medication(s) and all necessary supplies/equipment.
- ❑ I understand that I must administer the first dose of any new medicine.
- ❑ I understand that ALL medicines (Prescription AND over-the-counter) must be in ORIGINAL LABELED CONTAINER.
- ❑ Prescription medicines must be labeled by a Pharmacist with Student's name, name of the Medication, date filled, expiration date, directions for administration, and name of Prescriber.
- ❑ I authorize the Medication(s) and Treatment Plan to be administered to my child as directed on this form.
- ❑ I understand it is my responsibility to communicate changes in my child's Diabetes management including dosages, parameters, carbohydrate ratios, correction factors & targets and his/her Diabetes Disaster Plan.
- ❑ I understand the Prescriber will be called if any questions arise related to the Medication(s) or Treatment Plan.
- ❑ Diabetes Care Provider_____Phone:_____Fax:_____
- ❑ I authorize the release any information necessary for the prudent care of my child.
- ❑ I understand that 911 will be called immediately in an emergency, and then Parents will be notified ASAP thereafter.

Parent/Guardian Printed Name_____Home Phone _____
Mom cell_____Work#_____Dad cell_____Work#_____
Mom email_____Dad email _____
Additional Contact Info_____
#1 Emergency Contact Name_____Relationship _____
Home Phone_____cell_____Alternate contact_____
#2 Emergency Contact Name_____Relationship _____
Home Phone:_____cell_____Alternate contact_____

☐ Send report of all glucose monitoring results & insulin administration to parent_____via:
specify frequency
Fax_____email_____Other_____

☐ Call Parent if Blood Glucose <_mg/dl ***OR*** >_____mg/dl ☐ Other Instructions: _____

_____

Parent/Guardian Signature _____ **Date** _____

To be Completed by Authorized Health Care Provider:

BLOOD GLUCOSE TESTING: Target Range for Blood Glucose monitoring at School _____
☐ No Testing at School ☐ Before snacks ☐ Before Lunch ☐ 2 hr OR_____after lunch ☐ 2 hr OR_____after correction
☐ PRN suspected hypo/hyperglycemia ☐ PRN suspected illness ☐ Carries meter at all times & tests PRN s/s hypo/hyperglycemia

STUDENT is Authorized to INDEPENDENTLY perform the following at School:
(Student may still require assistance and/or supervision interpreting BG results and all Insulin administration; verify skills with Parents)
☐ Blood Glucose testing ☐ Determining Insulin dose ☐ Measuring Insulin ☐ self-injecting Insulin ☐ Operating Insulin Pump
☐ Other: _____

MEAL PLAN ***Provide liquid and solid carbohydrate sources to be available in the Health Room at all times***
☐ Regular meals & snacks ☐ AM Snack time _____ ☐ Regular Lunch /no restrictions ☐ PM snack time _____
☐ Extra food allowed (specify) _____ ☐ at Parents' discretion ☐ at Student's discretion
☐ Other: _____

Student Name: _____

INSULIN ORDERS: Brand name & type Insulin(s): _____

Insulin Administration via: ☐ syringe & vial ☐ Insulin Pen ☐ Other: _____
☐ Insulin Pump Type of pump_____ Basal rates _____

Dose Times: ☐ Breakfast _____ ☐ AM Snack _____ ☐ Lunch _____ ☐ PM Snack _____ ☐ Other _____

Insulin before Lunch/Meals: ☐ Routine Lunchtime Dose:_____
☐ Per Sliding Scale as follows:
Blood Glucose from_____to_____give_____units
Blood Glucose from_____to_____give_____units
Blood Glucose from_____to_____give_____units
Blood Glucose from_____to_____ give_____units

*Carbohydrate ratios (CI), Correction Factors (CF) and Targets are subject to frequent change within the following guidelines:
CI = 1:5-1:50
CF = 1:20-1:100
CF Target = 70-180

COUNTING CARBOHYDRATES, with INSULIN BOLUS/CORRECTION for ALL CARBOHYDRATES, as follows:

☐ Calculated Insulin Dose: add Carbohydrate coverage + calculated Correction Dose together for Total Insulin Dose/Bolus
Carbohydrate Coverage: Insulin to Carbohydrate Ratio: Give_____units Insulin per_____grams Carbohydrate
☐ Correction Factor with meals: Give_____# Units for every_____mg/dl above_____mg/dl
☐ Decrease Correction by_____% Unit(s) if Phys Ed or increased activity anticipated following the Correction Dose or if last dose given less than 2 hours earlier
☐ Other times: ☐ Snack: routine dose_____ ☐ calculated as above ☐ if BG_____Give _____
☐ Ketones; if Moderate/Large, Give/add: _____

HYPOGLYCEMIA – BLOOD GLUCOSE less than_____mg/dl:

☐ Self Treatment of mild hypoglycemic lows {*Parent may provide chart with recommended carb amts for BG < target*}
☐ Nurse assistance/supervision for ALL low BGs
☐ Provide_____grams fast-acting carbohydrate according to Care Plan; Re-check BG in 10-15 min; Repeat treatment if BG < 70mg/dl
☐ Provide extra protein & carbohydrate snack after treating low if next meal/snack is greater than_____minutes away
☐ Suspend pump for severe hypoglycemia for_____minutes

*****If unable to swallow, having a seizure or is unconscious, presume Hypoglycemia and CALL 911, then notify Parent*****

☐ Administer Glucose Gel (place inside cheek), even if post-ictal/unconscious
*if given, place Student in *rescue position* (on side) after dosing*
☐ Glucagon Injection (1mg/ml) for severe hypoglycemia <_____mg/dl; Give:_____mg SQ *or* IM

HYPERGLYCEMIA – BLOOD GLUCOSE greater than_____mg/dl:

☐ Check Urine Ketones, Follow Care Plan and administer insulin as per orders ☐ for pumps, Insulin may be given by syringe or pen
☐ Encourage sugar-free fluids, BRP as needed, and Student may return to class if feeling OK (no GI upset or abdominal pain)
☐ If Student complains of nausea, vomiting or abdominal pain, check Urine Ketones & check Insulin administration orders
☐ If Urine Ketones are Moderate to Large, send Student home & instruct to contact Provider for further instructions
☐ Emergency Room transport may be necessary if Ketones are Large AND accompanied by vomiting; call 911 PRN

EXERCISE : *Have fast-acting carbohydrate sources available before, during and after ALL exercise activities*

☐ Snack kept with Student ☐ Snack kept with Teacher
☐ No exercise if most recent BG < 70 ☐ Student may resume exercise once BG corrected and > 70mg/dl
☐ Eat_____grams Carbohydrate for vigorous exercise ☐ Before exercise ☐ Every 30 min during exercise ☐ After vigorous exercise
☐ No exercise when BG > 350 or_____mg/dl *AND* if Ketones are Moderate to Large

BUS or other TRANSPORTATION for FIELD TRIPS and other off-campus Activities:

☐ Blood Glucose monitoring not required prior to boarding bus
☐ Check Blood Glucose 15 minutes prior to boarding bus
☐ Allow Student to eat on bus if having symptoms of low Blood Glucose
☐ Provide care as follows: _____

DISASTER PLAN: (if needed for lock-down / 24 hr shelter-in-place)

☐ Follow insulin orders as on Management Form for all carbohydrate ratios and corrections
☐ Additional Insulin orders as follows: Carbohydrate to Insulin ratio at Breakfast is 1: _____ At Dinner is 1: _____
☐ Administer long-acting Insulin as follows: Lantus_____ units in PM
☐ Other: _____

Specify ADDITIONAL INSTRUCTIONS on PHYSICIAN / LHCP's Stationery or Prescription Pad & Attach to this ACTION PLAN

Printed Name:_____Phone_____Fax _____

Signature:_____ Date: _____

Reviewed by School Nurse:_____Date: _____
Printed Name & Ttitle / Signature

Adapted from MD State Mgmt of Diabetes at School/ Order Form; RevJun2017jhm