HS0024
Rev. 3/23

DIABETES ACTION PLAN

Health Services Department
Lincoln Public Schools • Lincoln, Nebraska

This plan is valid for the current school year: _____ - _____

Student Name: _____ DOB: _____

Date of Diabetes Diagnosis: _____ ❑ Type 1 ❑ Type 2 ❑ Other: _____

School: _____ Grade: _____ Home Room Teacher: _____

STUDENT SCHEDULE

Check all that apply

BEFORE SCHOOL	MEALS AT SCHOOL	SCHOOL ACTIVITIES	AFTER SCHOOL GOES TO
❑ Arrives by Walk/Bike ❑ Arrives by Car ❑ Arrives by Bus ❑ Attends Before School Program ❑ Before School Class/ Club/Group ❑ Before School Sport	❑ Breakfast ❑ AM Snack ❑ Lunch ❑ PM Snack ❑ Pre-Dismissal Snack	**Before School** ❑ Gym ❑ Recess ❑ Sports ❑ School Clubs/Groups **After School** ❑ Sports ❑ School Clubs/Groups ❑ Class	❑ Home ❑ After School Program/ Sport via: ❑ Walk/Bike ❑ Car ❑ Bus

****Parent will notify the Health Office of any before or after school clubs, sports or classes their student will attend. Health Services will determine appropriate staffing.***

CONTACT INFORMATION

Parent/Guardian 1: _____ Email Address: _____

Address: _____

Telephone Home: _____ Work: _____ Cell: _____

Parent/Guardian 2: _____ Email Address: _____

Address: _____

Telephone Home: _____ Work: _____ Cell: _____

Student's Physician/Health Care Provider: _____

Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contact

Name: _____ Relationship: _____

Telephone Home: _____ Work: _____ Cell: _____

SUPPLIES

The **School** will ensure supplies are accessible at all times (class, gym, field trips, fire drills, lock down, working, etc.) Advise parent/guardian when running low on supplies.
Parent/Guardian will maintain and restock all supplies and equipment.

SUPPLIES *(check all that apply)*	WITH STUDENT	CLASSROOM	HEALTH OFFICE	OTHER LOCATIONS
Blood Glucose Meter, Test Strips, Lancets	❑	❑	❑	❑
Fast-Acting Sugar (Juice, Glucose Tabes) for Low Sugar	❑	❑	❑	❑
Carbohydrate Snack(s)	❑	❑	❑	❑
Glucagon *(expiration date:_____)*	❑	❑	❑	❑
Ketone Strips/Meter	❑	❑	❑	❑
Insulin Pen, Needles and Insulin *(in case of pump failure)*	❑	❑	❑	❑
Extra Batteries for Meter	❑	❑	❑	❑
Device for CGM *(i.e. iPad, phone)*	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑

CHECKING BLOOD GLUCOSE

Brand/Model of Blood Glucose Meter: _____

Target Range of Blood Glucose: _____

Before Meals: ❑ 90-130 mg/dL ❑ Other: _____

Check Blood Glucose Level:

❑ Before Breakfast ❑ After Breakfast ❑ ____hrs After Breakfast ❑ 2 Hours After Correction Dose
❑ Before Lunch ❑ After Lunch ❑ ____hrs After Lunch ❑ Before Dismissal
❑ Mid-Morning ❑ Before PE ❑ After PE ❑ Other: _____
❑ As Needed for Signs/Symptoms of Low or High Blood Glucose
❑ As Needed for Signs/Symptoms of Illness

Student's Self-Care Blood Glucose Checking Skills:

❑ Independently Checks Own Blood Glucose
❑ May Check Blood Glucose with Supervision
❑ Requires a School Nurse or Trained Diabetes personnel to Check Blood Glucose
❑ Uses a Smartphone or Other Monitoring Technology to Track Blood Glucose Value

Continuous Glucose Monitor (CGM): ❑ Yes ❑ No Brand/Model:
Blood Glucose Check to Be Used for Hypo/Hyper Glycemic Management ❑ Yes ❑ No
Alarms Set for: Severe Low:_____ Low:_____ High:_____
Predictive Alarm: Low:_____ High:_____ Rate of change: Low:_____ High:_____
Threshold Suspend Setting: _____
CGM May Be Used for Insulin Calculation if Glucose is Between _____-_____mg/dL ❑ Yes ❑ No
CGM May Be Used for Hypoglycemia Management ❑ Yes ❑ No
CGM May Be Used for Hyperglycemia Management ❑ Yes ❑ No

Additional information for student with CGM

- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-Care CGM Skills:	**Independent**	
The Student Troubleshoots Alarms and Malfunctions	❑ Yes	❑ No
The Student Knows what to Do and is Able to Deal with a High Alarm	❑ Yes	❑ No
The Student Knows what to Do and is Able to Deal with a Low Alarm	❑ Yes	❑ No
The Student Can Calibrate the CGM	❑ Yes	❑ No
The Student Knows what to Do when the CGM Indicates A Rapid Trending Rise or Fall in the Blood Glucose Level	❑ Yes	❑ No
The Student Should be Escorted to the Nurse if the CGM Alarm Goes Off:	❑ Yes	❑ No

Other Instructions for the School Health Team:

_____

HYPOGLYCEMIA TREATMENT

Student's usual symptoms of hypoglycemia (list below):

_____

If exhibiting symptoms of hypoglycemia, **OR** if blood glucose level is less than _____ mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment:

_____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions:

- Position the student on his or her side to prevent choking
- Administer glucagon: Name of glucagon used: _____

Injection

Dose:	❑ 1 mg	❑ 0.5 mg	❑ Other (dose): _____	
Route:	❑ Intramuscular	❑ Subcutaneous		
Site:	❑ Thigh	❑ Arm	❑ Buttocks	❑ Other: _____

Nasal

Dose:	❑ 3mg	❑ Other (dose): _____

Additional Information

- Call 911 (Emergency Medical Services) and the student's parent/guardian.
- Contact the student's health care provider.
- If on an insulin pump, stop by placing mode in suspend or disconnect. Always send the pump with EMS to the hospital.

HYPERGLYCEMIA TREATMENT

Student's usual symptoms of hyperglycemia (list below):

_____

- Check ❑ Urine ❑ Blood for ketones every _____ hours when blood glucose levels are above _____ mg/dL.
- For blood glucose greater than _____ mg/dL **AND** at least _____ hours since last insulin dose, give a correction dose of insulin (see correction dose orders).
- Notify parent/guardian if blood glucose is over _____ mg/dL
- For insulin pump users: See Additional information **(pg. 6)** for students with insulin pumps.
- Give extra water and/or non-sugar containing drinks (not fruit juices)

Additional treatment for ketones:

_____

Additional Information

- If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parent/guardian and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing of shortness of breath, chest pain, increasing sleepiness or lethargy or depressed level of consciousness.

INSULIN THERAPY

Insulin delivery device: ❑ Syringe ❑ Insulin Pen ❑ Insulin Pump

Type of insulin therapy at school: ❑ Adjustable (basal-bolus) Insulin ❑ Fixed Insulin Therapy ❑ No Insulin

Adjustable (basal-bolus) Insulin Therapy:

- Carbohydrate Coverage/Correction Dose: Name of insulin: _____
- Carbohydrate Coverage:
  - Insulin to carbohydrate ratio:
    - Breakfast: 1 unit of insulin per _____ grams of carbohydrate
    - Lunch: 1 unit of insulin per _____ grams of carbohydrate
    - Snack: 1 unit of insulin per _____ grams of carbohydrate

CARBOHYDRATE DOSE CALCULATION EXAMPLE
Total Grams of Carbohydrate to be Eaten ÷ Insulin-to-Carbohydrate Ratio = _____ Units of Insulin

Correction Dose: Blood glucose correction factor (insulin sensitivity factor) = _____

Target Blood Glucose = _____ mg/dL

CORRECTION DOSE CALCULATION EXAMPLE
Current Blood Glucose − Target Blood Glucose ÷ Correction Factor = _____ Units of Insulin

Correction Dose Scale *(Use instead of calculator above to determine insulin correction dose)***:**

Blood Glucose _____ to _____ mg/dL, give _____ Units

Blood Glucose _____ to _____ mg/dL, give _____ Units

Blood Glucose _____ to _____ mg/dL, give _____ Units

Blood Glucose _____ to _____ mg/dL, give _____ Units

USING BOTH CARBOHYDRATE DOSE AND CORRECTION DOSE CALCULATION EXAMPLE

- Complete calculations as in above boxes for Carbohydrate Dose example and Correction Dose example.
- Then add the totals together

Carbohydrate Dose total units + Correction Dose total units = _____ units of insulin.

- Round amount depending on syringe/pen measurement marks ❑ 0.5 units ❑ full unit to = units of insulin to give/take for snack/meal dosing.

When to Give Insulin During the School Day

Breakfast

❑ Carbohydrate Coverage Only

❑ Carbohydrate Coverage plus Correction Dose when Blood Glucose is Greater than _____ mg/dL and _____ Hours Since Last Insulin Dose

❑ Other: _____

Lunch

❑ Carbohydrate Coverage Only

❑ Carbohydrate Coverage plus Correction Dose when Blood Glucose is Greater than _____ mg/dL and _____ Hours Since Last Insulin Dose

❑ Other: _____

Snack

❑ No Coverage for Snack

❑ Carbohydrate Coverage Only

❑ Carbohydrate Coverage plus Correction Dose when Blood Glucose is Greater than _____ mg/dL and _____ Hours Since Last Insulin Dose

❑ Correction Dose Only: For Blood Glucose Greater than mg/dL AND at Least Hours Since Last Insulin Dose

❑ Other: _____

Fixed Insulin Therapy

Name of Insulin:

❑ Units of Insulin Given Pre-Breakfast Daily

❑ Units of Insulin Given Pre-Lunch Daily

❑ Units of Insulin Given Pre-Snack Daily

❑ Other: _____

Other Diabetes Medications

Name: _____ Dose: _____ Route: _____ Times Give: _____

Name: _____ Dose: _____ Route: _____ Times Give: _____

Additional Information

- The build-up in insulin levels following repeated injection of insulin at close intervals—referred to as insulin stacking— can increase the risk of hypoglycemia.

Student's Self-Care Insulin Administration Skills

❑ Independently Calculates and Gives Own Injections

❑ May Calculate/Give Own Injections with Supervision

❑ Requires School Nurse or Trained Diabetes Personnel to Calculate Dose and Student Can Give Own Injection with Supervision

❑ Requires School Nurse or Trained Diabetes Personnel to Calculate Dose and Give the Injection.

Additional Information for Student with Insulin Pump

Brand/Model of Pump: _____ Type of Insulin Pump: _____

Type of Infusion Set: _____

Appropriate Infusion Set: _____

- ❑ For Blood Glucose Greater than _____ mg/dL that has Not Decreased within _____ Hours After Correction, Consider Pump Failure or Infusion Site Failure. Notify Parents/Guardians.
- ❑ For Suspected Pump Failure: Suspend or Remove Pump and Give Insulin by Syringe or Pen.
- ❑ For Insulin Site Failure: Insert New Infusion Set and/or Replace Reservoir, or Give Insulin by Syringe or Pen.

  Doctors order needed for the nurse to re-insert. If a nurse is not available or a student is on a field trip, parent will need to re-insert.
- ❑ For Suspected Pump Failure: Suspend or Remove Pump and Give Insulin by Syringe or Pen.

Other Pump Instructions: _____

Physical Activity

May Disconnect from Pump for Sports Activities ❑ Yes, for _____ Hours ❑ No

Student's Self-Care CGM Skills:	**Independent**	
Counts Carbohydrates	❑ Yes	❑ No
Calculates Correct Amount of Insulin for Carbohydrates Consumed	❑ Yes	❑ No
Administers Correction Bolus	❑ Yes	❑ No
Calculates and Sets Basal Profiles	❑ Yes	❑ No
Calculates and Sets Temporary Basal Rate	❑ Yes	❑ No
Changes Batteries	❑ Yes	❑ No
Disconnects Pump	❑ Yes	❑ No
Reconnects Pump to Infusion Set	❑ Yes	❑ No
Prepares Reservoir, Pod and/or Tubing	❑ Yes	❑ No
Inserts Infusion Set	❑ Yes	❑ No
Troubleshoots Alarms and Malfunctions	❑ Yes	❑ No

MEALS/SNACKS

MEAL/SNACK	TIME	CARBOHYDRATE COUNT *(grams)*
Breakfast		_____ to _____
Mid-Morning Snack		_____ to _____
Lunch		_____ to _____
Mid-Afternoon Snack		_____ to _____

Other Times to Give Snacks and Content/Amount: _____

Instructions for when Food is Provided to the Class (i.e. as part of a class party or food sampling event):

_____

Special Event/Party Food Permitted ❑ Parent/Guardian Discretion ❑ Student Discretion

Is a Special Diet Needed ❑ Yes ❑ No

If Yes, ***Special Diet Medical Statement*** is required (NS0002)

Student's Self-Care Nutritional Skills:

- ❑ Independently Counts Carbohydrates
- ❑ May Count Carbohydrates with Supervision
- ❑ Requires School Nurse/Trained Diabetes Personnel to Count Carbohydrates

PHYSICAL ACTIVITY AND SPORTS

A quick-acting source of glucose as ❑ glucose tabs and/or ❑ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat ❑ 15 grams ❑ 30 grams ❑ other:

❑ Before ❑ Every 30 minutes during ❑ Every 60 minutes during ❑ After vigorous physical activity

❑ Other: _____

If most recent blood glucose is less than _____mg/dL, student can participate in physical activity when blood glucose is corrected and above _____mg/dL.

Avoid physical activity when blood glucose is greater than _____mg/dL or if urine/blood ketones are moderate to large.

DISASTER/EMERGENCY AND CLASSROOM PLAN

SCHOOL EMERGENCY & SAFETY PLAN: Please share information for a school evacuation, relocation or lock down situation ***(ex. Parent will provide an extra fast-acting source of glucose and snacks containing carbohydrates and protein. Parent will provide extra supplies for classroom).***

Parent to notify Health Office of changes to this Diabetic Medical Management Plan by:

❑ Phone: _____ ❑ E-mail: _____ ❑ Both email & phone

PARENT/GUARDIAN SIGNATURE

I, (parent/guardian) _____ give permission to the school nurse or another qualified healthcare professional or trained diabetes personal to perform and carry out the diabetes care tasks as outlined above. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified healthcare profession to contact my child's physician/health care provider. I also understand a new authorization is required for each school year and/or when medical orders change.

_____ _____

Student's Parent/Guardian *Date*

_____ _____

School Nurse *Date*

	FOR OFFICE USE ONLY
DATE	**ANNUAL REVIEW COMMENTS**