Diabetes Action Plan

Place Child's Picture Here

Student's Name _____ D.O.B. _____ Teacher _____

School _____ Plan Expires _____

Parent/Guardian Name _____

Home Phone _____ Cell Phone _____ Work Phone _____

Blood Glucose Testing

	Done with adult assistance		May be done in classroom
	May test self		Prefer done out of classroom
	Done daily prior to lunch		Urine ketone testing if needed (see Student's Diabetic Medical Management Plan from Physician)
	Done also as needed		

Low Blood Sugar

Intervention if blood sugar is below _____ mg/dl	
	Notify parent
	4 oz. juice (15 grams carbohydrate) or snack
	3 glucose tabs (15 grams carbohydrate)
	Glucose gel (3 teaspoons) (15 grams carbohydrate)
	Recheck blood sugar in 10-15 minutes
See Hypoglycemia, low blood sugar emergency plan for further detail	
If student is unable to chew or swallow, seizure, or unconscious give injectable glucagon as prescribed; call 911, notify parent	

High Blood Sugar

Intervention if blood sugar is above _____ mg/dl	
	Notify parent
	Insulin coverage as prescribed in Student's Diabetic Medical Management Plan from Physician
See Hyperglycemia, high blood sugar emergency plan	

Insulin Injection

	Student will need _____(type) insulin at _____ a.m./p.m. in the amount of one unit for every _____ grams of carbohydrate; and 1 unit of insulin for every _____mg/dl the blood sugar is above 150 mg/dl.
	If the insulin changes, the **parent** will inform the school.
	The student uses an insulin pen device.
	The student uses/wears an insulin pump.
**	The parent/guardian will instruct school staff on the route of insulin delivery and notify if that route changes.

Parent/Guardian Signature _____ Date _____

Doctors Signature (Required) _____ Date _____

cc: Office
CA60 File
Transportation
Food & Nutrition Department
SACC
Sponsors/Athletics
Teachers