

CLOVIS MUNICIPAL SCHOOLS DIABETIC ACTION PLAN

This Action Plan is to be completed and signed by the child's parent/guardian and physician. The information on this plan is confidential. All staff that cares for your child will have access to this information in order to provide optimal safety in the school setting. Please contact the school at any time if you need to update this Action Plan.

Student Name _____ DOB _____ Grade _____

Parent/Guardian Name _____ Ph: (h) _____

Address _____ Ph: (w) _____ Ph: (c) _____

Parent/Guardian Name _____ Ph: (h) _____

Address _____ Ph: (w) _____ Ph: (c) _____

Emergency Phone Contact #1 _____

Name Relationship Phone #

Emergency Phone Contact #1 _____

Name Relationship Phone #

Physician Treating Student for Diabetes _____

Name Phone #

Other Physician _____

Name Phone #

Blood Glucose Monitoring

- Blood glucose range: _____ mg/dl to _____ mg/dl
- Routine times to test blood glucose _____
- Times to do extra blood glucose tests (check all that apply)

<input type="checkbox"/> Before exercise	<input type="checkbox"/> Shows symptoms of Hyperglycemia
<input type="checkbox"/> After exercise	<input type="checkbox"/> Shows symptoms of Hypoglycemia
<input type="checkbox"/> Other (explain): _____	

Can student perform own glucose tests? Yes No

Insulin – types, times and usual dosages of Insulin injections at school: (Attach sliding scale if needed)

<u>Time</u>	<u>Types</u>	<u>Dosage</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Can student administer own insulin injections? Yes No

Can student determine and draw correct dose of insulin? Yes No

Insulin Pump

Type of Pump: _____

Orders: _____

Is student competent to operate insulin pump? Yes No

Oral Agents

<u>Time</u>	<u>Types</u>	<u>Dosage</u>
_____	_____	_____
_____	_____	_____

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Carbohydrate Counting

Insulin/Carbohydrate Ratio: _____ Correction Factor: _____

Location of Supplies – at school

Blood Glucose test equipment: _____

Insulin: _____

Ketostix: _____

Glucagon: _____

Snack Foods: _____

Meals and Snacks Eaten at School

<u>Meal/Snack</u>	<u>Time</u>	<u>Food Content/Amount</u>
Breakfast	_____	_____
AM snack	_____	_____
Lunch	_____	_____
PM snack	_____	_____
Snack before exercise?	_____	_____
Snack after exercise?	_____	_____
Other snack times:	_____	_____

Instructions for class parties: _____

Exercise and Sports

Snacks to have available for sports/exercise: _____

Activity Restrictions (if any): _____

Student **should not exercise** if blood glucose is **below** _____ mg/dl.

- o Snack listed above should be given: Yes No

Student **should not exercise** if blood glucose is **above** _____ mg/dl.

- o Ketones should be checked: Yes No

Notify physician and parents if urine ketones are present: Yes No

Parent Signature _____ **Date** _____

Physician Signature _____ **Date** _____

➡➡➡ **Please also complete the Diabetes Emergency Response Plan. Thank you.**