BPS 101 Diabetes Action Plan

Name of Student_____ DOB _____ Date _____
Physician: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Blood Glucose Monitoring:
Target Range for Blood Glucose: _____mg/dl
Times to check blood glucose: _____ With symptoms of hypo/hyperglycemia
_____ Before am snack
_____ Before lunch
_____ Before/after exercise
_____ Other
_____ Student may carry own meter and supplies

Student is able to: (circle all that apply)

Test own glucose	yes	no
Determine insulin dose	yes	no
Draw up insulin	yes	no
Administer insulin dose	yes	no
Manage/troubleshoot pump	yes	no

Exercise/sports:
Student should not exercise if blood glucose is below _____ or above _____

Hypoglycemia Treatment (low blood glucose): Treat if BG under _____. If blood glucose is less than 70 mg/dl or symptomatic (70-100mg/dl) eat/drink 15 grams of carbohydrate. Check BG in 15 minutes, if not above 70 mg/dl repeat treatment. Check BG in 15 minutes if not above 70 mg/dl repeat treatment and contact parents.
Severe Hypoglycemia Treatment (i.e. loss of consciousness, unable to cooperate, seizure)
_____ Glucagon _____mg SQ in arm or thigh (separate Medication form)
_____ Call 911 and parents.

Hyperglycemia Treatment (high blood sugar):
_____ Provide water and access to bathroom
_____ Test urine ketones if blood glucose is greater than _____
_____ Call parent if moderate/large ketones

Insulin: _____ SQ Insulin _____ Insulin Pump Type of Insulin Pump _____
Type of Insulin: _____

Insulin to carbohydrate ratio (I:CR): _____ unit(s) / _____ grams
Correction Factor (CF): _____unit(s) per _____mg/dl over _____mg/dl

Health Care Provider Signature: _____ Date:___

Office Contact Number _____

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name:_____

Important Phone Numbers:

Parent/Guardian #1

Name: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Parent/Guardian #2

Name: _____
Home Phone:_____
Cell Phone: _____
Work Phone: _____

Emergency Contact #1
Name: _____
Relationship:_____
Relationship:_____
Home Phone: _____
_____
Cell Phone: _____
_____
Work Phone: _____
_____

Emergency Contact #2
Name: _____

Home Phone:

Cell Phone:

Work Phone:

Supplies for school to be provided by parents:

Blood glucose monitor kit and all monitoring supplies (meter, testing strips, lancing device), Insulin and administration supplies, Glucagon emergency kit, snack foods, fast acting glucose source (juice, snacks, glucose tabs), ketone testing supplies and Insulin Pump supplies (if appropriate).

_____ I hereby certify that the above information is complete and I have provided the school with all the information that they will need to reasonably care for and monitor my child's health related to diabetes. I give permission for the school to talk to my prescribing doctor, nurse practitioner, physician assistant and/or nurse. (Please place check mark on line above)

_____ I hereby certify that my child can monitor and manage his/her care without supervision from school personnel except in emergency circumstances. (Please place check mark on line if applicable)

Parent/Guardian:
I give permission to Batavia School District 101 to administer/supervise the medication described in accordance with the school district's regulations governing the administration of medications in the schools.

_____ _____

Parent/Guardian Signature **Date**

3/17