Diabetic Action Plan

School ______________________________________

School Year __________________________ **Date** ________________

Student Name: _________________________________ Date of Birth: ___________
Teacher: ____ Grade Level: ___________
Parents/Guardians: ____
Home Phone: ___________________ Work Phone (Mother): _________________
Cell Phone: ______________________ Work Phone (Father): _________________

Emergency Contact: ____
Name Relationship Phone

Emergency Contact: ____
Name Relationship Phone

Physician: ____ Phone: _______________

I understand that it is my responsibility as the parent/guardian of ___________________ to notify the school nurse/medical professional or designee of any changes in my child's health condition and/or medication/treatment regimen. As parent or legal guardian of the above named student, I understand that my signature on this document authorizes representatives of Henry County Schools to communicate about/receive information regarding my child/ward from my child's physician and his/her staff. I understand that this health information will only be shared with pertinent school staff.

___________________________________ ____________________________
Parent/Guardian Signature Date

Completed by Physician

Type of Diabetes: ____

Has student had hospitalization in the past year for Diabetes? ________________________
If yes, when? ____
How will this illness impact school attendance? ____________________________________
____

Current Insulin Regimen:

A.M. ______________________________________
Type-Dose-Time

Lunch ______________________________________
Type-Dose-Time

Dinner ______________________________________
Type-Dose-Time

Bedtime ____________________________________
Type-Dose-Time

Diabetic Supplies Stored at School

Blood Glucose Testing Kit ____ Insulin _____
Glucagon _____ Blood Glucose Log _____
Urine Ketone Testing Kit _______ Syringes _____
Sharps Disposal Contanger _____

Snack for Hypoglycemia
____

Location for the above supplies
____

Will student require Insulin at school? ____ Yes _____ No
Can student give his/her Insulin? ________ Yes _____ No
Will student need supervision in giving own Insulin? ________ Yes _______ No

Pump Information:

____
____
____

Blood Glucose Monitoring:
Target range of blood glucose is ____________ mg/dl to ___________________ mg/dl

Will student require routine glucose monitoring at school? __________ Yes ________________ No
Can student test his/her own blood glucose level? _____________ Yes _________________ No
Will student require supervision with blood glucose monitoring? ______________ Yes _________ No
Will student require supplemental testing time?
__________ Before exercise
__________ After exercise
__________ Before snack
__________ With symptoms of high/low
__________ Other

Does student check urine for glucose? ___________ Yes ________________ No
Will student need assistance with urine testing? _____________ Yes _____________ No
Routine time for urine testing: _________________________

Dietary guidelines:

Estimated total calories per day: _____________________________
Meal/Snack Times:
Breakfast @ ___________________ a.m.
Snack @ _______________________a.m.
Lunch@ _______________________ a.m.
Snack@ ________________________p.m.
Dinner@ _______________________p.m.
Bedtime@ ______________________p.m.
Will student need to be reminded to take a snack? _____________ Yes ______________ No
(Snacks are to be provided by parents)
Modifications for parties:
____

Physical Activity:
Does the student have restrictions regarding physical activity? ____________ Yes _____________ No
(Exercise/sports limitations)
Describe:
____
____

Is a snack required before physical activity? _______________ Yes ___________________ No
Snack given before activity if: ____
Exercise should be delayed or avoided if the blood is higher than ________ mg/dl and lower than ________mg/dl

Emergency Services for School:
HYPOGLYCEMIA – Insulin reaction
How often do hypoglycemic reactions occur? ____
When is the usual time of day hypoglycemic reactions occur? _________________________________
Student's symptoms: ____
Treatment:
____

HYPERGLYCEMIA – High Blood Glucose
Student's symptoms: ____
Treatment:
____

______________________________ ___________________________________ ______________
Physician Printed Name Physician Signature Date