



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
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Emergency Contact: _____

	Name	Relationship	Phone
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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 Container _____	
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:



Student Name _____

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
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