St. Theresa School Diabetes Management Action Plan (2018-2019)

I

Student _____ Grade _____ DOB _____
Parents/Guardians _____Mom Phone: _____
Parents/Guardians _____Dad Phone: _____
Emergency Contact _____ Phone _____
Date of Diagnosis_____ ☐ Type 1 ☐ Type 2

Checking Blood Glucose Level

- ☐ Target ranges _____
- ☐ Check blood glucose level (list times) _____
- ☐ Check before dismissal. If low _____ If high _____
- ☐ As needed for signs or symptoms of illness

Preferred site of testing _____ Preferred site of injections _____

- ☐ Independently checks their own blood glucose
- ☐ May check blood level with supervision
- ☐ Requires school nurse or trained adult to check blood glucose

Continuous Glucose Monitoring (CGM):

Yes ☐ No ☐ Brand _____

Confirm CGM results with blood glucose meter before taking action on sensor blood glucose level.
If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level.

Hypoglycemia Treatment

Usual symptoms: _____

- ☐ If exhibiting any of these symptoms OR if blood glucose level is less than _____mg/dL give a quick-acting glucose product to equal _____ grams of carbohydrate.
- ☐ Recheck blood glucose in 10-15 minutes & repeat treatment if blood glucose level is less than _____. Additional treatment _____
  If student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions give glucagon as directed on Physician Order and noted below.
- ☐ GLUCAGON: ☐ 1mg ☐ ½ mg ROUTE: ☐ SQ ☐ IM SITE: ☐ Arm ☐ Thigh ☐ Other
- ☐ CALL 911 and Student's parents / guardians.

Hyperglycemia Treatment

Usual symptoms: _____

- ☐ Check urine for ketones every hour when blood glucose levels are above _____ mg/dL Blood glucose greater than _____ AND at least _____ hours since last insulin dose, give correction dose of insulin, per attached MD orders.
- ☐ Give extra water and/or non-sugar containing drinks (no fruit juice) _____ounces per hour.
- ☐ Notify parents of onset of hyperglycemia situation.

☐ If student has symptoms of hyperglycemia emergency, including dry mouth, extreme thirst, nausea, vomiting, severe abdominal pain, heavy breathing or SOB, chest pain, increasing sleepiness or lethargy or depressed level of consciousness: CALL 911.

Insulin Therapy

Insulin delivery device at school: ☐ Syringe ☐ Insulin Pen ☐ Insulin Pump

Type of insulin at school ☐ No Insulin

☐ Fixed Insulin Therapy Insulin Name _____

☐ Adjustable Therapy Insulin Name _____

Carbohydrate Coverage/Correction Dose: Insulin to Carbohydrate Ratio: _____

Target blood glucose = _____ mg/dL Grams of carbohydrate in meal

Insulin to carbohydrate ratio = _____ Unit of _____ Insulin

Snack Insulin: ☐ No coverage for snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater Than _____ mg/dL & _____ hours since last dose

☐ Other _____

Lunch Insulin: ☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater Than _____ mg/dL & _____ hours since last dose.

☐ Other_____

Fixed Insulin Therapy: Name of Insulin _____

_____ Units of insulin pre-snack daily _____ Units of insulin pre-lunch daily

☐ **Parental Authorization to Adjust Insulin Dose:**

- ☐ Parents/Guardians authorization should be obtained before administering a correction dose.
- ☐ Parents/Guardians are authorized to increase or decrease correction dose scale.
- ☐ Students Self-care insulin administration skills:
- ☐ Independently calculated & gives own injections
- ☐ May calculate/give own injections with supervision
- ☐ Requires school nurse or trained diabetes personnel to calculate/give their injections.

Insulin Pump Information

Brand/Model of pump _____ Type of Insulin in pump _____

Basal rates during school _____ if available, attach setting report.

Type of infusion set: _____ Changed how often _____

☐ For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after a correction, consider a pump failure or infusion site failure. Notify parents / guardians.

☐ For infusion site failure, insert a new infusion set / replace the reservoir.

☐ For suspected pump failure: suspend or remove the pump and give insulin by syringe or pen.

Physical Activity: ☐ Nothing different

☐ Suspend pump use ☐ May disconnect from pump for sports activities

☐ Set a temporary basal rate _____% temp rate for _____ hours

Other Diabetes Medications_____

Meal / Snack / Example	Time	Carbohydrate Content (grams)
Breakfast		
Midmorning snack		
Lunch		
Mid afternoon Snack		
Other time to give snacks		

Instructions for when food is provided to the class: _____

Special event/party food permitted: ☐ Parents/Guardian discretion ☐ Student discretion

Student self-care nutrition skills: ☐ Student is independent at counting carbohydrates
☐ Student may count carbohydrates with supervision
☐ Requires school nurse or diabetes trained personnel to count

I, (parent) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel at St. Theresa School to perform and carry out the diabetes management as outlined for (son/daughter) _____.

I also consent to the release of the information contained in this Diabetes Management Plan to all school staff and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse to contact my child's health care provider, in case of emergency.

_____ _____

Parent / Guardian Date

St. Theresa School Student Agreement to Carry Insulin for Self-Medication (2018-2019)

I

1. Student has demonstrated the correct use of the equipment needed for the administration of insulin, including: application of needle to the insulin injector device, proper procedure of measuring insulin, proper procedure of injection of insulin and/or proper disposal of needle from insulin injector device, to health care provider or school health personnel.
2. Student agrees never to share any equipment needed for the injecting of insulin or diabetes care with another person.
3. Student agrees that his/her parents or assigned adult guardian are to be consulted before the administration of insulin, and that his/her parent will determine the amount of insulin to be given based on student's blood sugar(s) and past and projected activity of student.
4. Student agrees to contact school nurse or other school staff if student has trouble with insulin injector device, or has any ill effects after the injection of insulin.

Student Signature_____

Grade _____ Homeroom _____ Date _____

Parent/Guardian Acknowledgment

I give permission for my child _____ to carry an insulin injection device as prescribed by his/her physician. I understand that he/she must follow the rules listed above. I will notify the school of any changes in medication or my child's condition. I also have submitted the required forms needed to allow administration of medication at school, according to Archdiocesan, St. Theresa School and District 15 guidelines.

Parent/Guardian Signature_____ Date _____