Lincoln Park Performing Arts Charter School

Health Services

DIABETES ACTION PLAN

THE SCHOOL WILL USE THIS INFORMATION AS A DIABETES ACTION PLAN TO PROVIDE THIS STUDENT'S CARE AND TREATMENT AT SCHOOL

Student Name_________________________________ DOB__________ GR__________ School Year______________

Address____City_______________________ Zip__________

Parent/Guardian ______________________________E-mail ____

Home Phone_______________________ Work Phone______________________ Cell Phone__________________

Emergency Contact____________________________Relationship___________________ Phone________________

Child's Diabetes Physician____Phone_________________________

Student has ☐ Type 1 Diabetes ☐ Type 2 Diabetes

Notify parents/guardian in the following situation:____

Glucose Monitoring/Insulin Administration at School

Glucose Montitoring

☐Finger stick Before meals ☐ High/Low Symptoms☐ Before Exams☐ Before Activity☐ Before Leaving School☐

☐Continuous Glucose Monitoring (CGM) Brand&Model____

Specify Viewing Equipment: Device Reader☐ Smart Phone☐ Insulin Pump☐ Tablet☐ Smart Watch☐

*Permit student access to viewing devices at all times

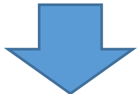
Insulin

Insulin Administered Via: Syringe☐ Insulin Pen☐ Insulin Pump☐ Brand&Model______________________________

LOW BLOOD GLUCOSE or hypoglycemia can be dangerous. If the student thinks their blood glucose is low, please allow him/her to check in the classroom or in the health office. If the student goes to the health office, **someone must accompany him/her.** My typical symptoms of low blood glucose include: None☐ Hungry☐ Shaky☐ Pale☐ Sweaty☐ Tired/Sleepy☐ Dizzy☐ Irritable☐ Unable to Concentrate☐ Confusion☐ Personality Changes☐ Other____________

If my blood glucose is less than: ☐ 70mg/dl **or** ☐ ____ mg/dl **I NEED TO EAT FAST-ACTING GLUCOSE QUICKLY**

1) Give ___grams of fast acting carbohydrate of one of the following (check):
   ☐ ___# of crackers ☐ ___oz juice ☐ ___gm of glucose gel ☐ ___glucose tablets ☐other_____________
2) If symptoms continue, restest in 15 minutes
3) If blood glucose remains less than ___mg/dl, retreat with____
4) Repeat above steps as needed
5) Troubleshoot the cause(s) of the low blood sugar if possible



If my blood glucose drops too low, I may be confused/unable to follow commands, unable to swallow, unconscious, or have a seizure. Glucagon is not life threatening even if it is given when not needed.

1) **Do not** give me anything by mouth.
2) **Give me Glucagon IM ☐ GVOKE SC ☐ Auto-Injection, GVOKE HYPOPEN ☐ Dose: 0.5mg ☐ or 1.0mg ☐ Other_____________________________**
3) Position me on my side, as there is risk of vomiting. Stay with me; do not leave me alone.
4) If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site.
5) Contact school nurse, parent/guardian and 911 if necessary.
6) Check blood glucose and no physical activity for ½ hr after use

HIGH BLOOD GLUCOSE is hyperglycemia. Symptoms include frequent urination and increased thirst. Severe cases of hyperglycemia can lead to ketoacidosis if left untreated. Ketoacidosis is life threatening and needs immediate treatment. Symptoms include shortness of breath, breath that smells fruity, nausea/vomiting and very dry mouth. My typical symptoms of high blood sugar include: None☐ Frequent Urination☐ Fatigued/Tired/Drowsy☐ Headache☐ Blurred Vision☐ Abdominal Discomfort☐ Nausea/Vomiting☐ Fruity Breath☐ Unaware☐ Other_______

If my blood glucose is greater than ☐300mg/dl or ☐ ___mg/dl I NEED TO TEST FOR KETONES IN THE HEALTH OFFICE

1) Provide and encourage consumption of water or sugar-free fluids (4-8oz every 30min). Allow to use bathroom
2) Administer inulin as ordered
3) Recheck blood sugar in 2 hours

The student must have a **parent/guardian permission** to both **self-carry AND to self-administer** the medication **on field trips**. The student must demonstrate to the school nurse that the student is responsible to safely self-carry and/or safely self-administer the medication.

STUDENT IS PERMITTED TO DO THE FOLLOWING ON SCHOOL FIELD TRIPS:

☐ **SELF-CARRY INSULIN/GLUCAGON** ☐ **SELF-ADMINISTER INSULIN/GLUCAGON**

☐ **PHYSICIAN IS IN AGREEMENT WITH SELF-MANAGEMENT ON FIELD TRIPS**

I GIVE PERMISSION TO THE SCHOOL NURSE OR ANOTHER QUALIFIED HEALTH CARE PROFESSIONAL TO COLLABORATE WITH MY CHILD'S PHYSICIAN/HEALTH CARE PROVIDER YES ☐ NO ☐

I CONSENT TO THE RELEASE OF THE INFORMATION CONTAINED IN THE DIABETIC ACTION PLAN TO ALL SCHOOL STAFF MEMBERS WHO HAVE RESPONSIBILITY FOR MY CHILD AND WHO MAY NEED TO KNOW THIS INFORMATION TO MAINTAIN MY CHILD'S HEALTH AND SAFETY YES ☐ NO ☐

Parent/Guardian Signature____Date:_________________________