DIABETES ACTION PLAN

Student's Name: ___________________________ Date of Birth: ___________________________
Date of Plan: ___________________________ This plan is valid for the current school year: __________ - __________
Date of Diabetes Diagnosis: ___________ □ type 1 □ type 2 □ Other ___________

CHECKING BLOOD GLUCOSE: TARGET RANGE of blood glucose: ___________________________
Check blood glucose level: □ Upon arrival at school □ Before lunch □ _____ Hours after lunch
□ 2 hours after a correction dose □ Before PE □ After PE □ Before dismissal
□ Other ___________________________

Student's self-care blood glucose checking skills:
□ Independently checks own blood glucose
□ May check blood glucose with supervision
□ Requires school nurse or trained diabetes personnel to check blood glucose

BLOOD GLUCOSE TREATMENT

BELOW_____ Give fast acting carbohydrate: 4 oz juice OR 15 gm glucose gel OR ___________________________
Observe for 15 minutes and retest blood glucose, if less than _____, repeat fast acting carbohydrate. If over _____ give crackers and cheese OR crackers and peanut butter.

*If student becomes unconscious, has a seizure or is unable to swallow: call 911; turn student on side; administer: □ 15 gm glucose gel □ 1 mg/1 ml glucagon IM; notify parent/guardian.

ABOVE_____ □ check ketones; □ administer insulin per sliding scale; □ provide _____ oz of water per hour; □ Other: ___________________________; notify parent/guardian.

*If student vomits, becomes lethargic, or has labored breathing: call 911; notify parent/guardian.

With a physician’s signed orders (listed below), and a parent/guardian completed medication permit form, the student may self-administer insulin according to the sliding scale listed.

SLIDING SCALE for INSULIN ADMINISTRATION

• Carbohydrate Coverage: 1 unit of insulin per _____ grams of carbohydrates.
• Correction Dose:
□ (Current Blood Glucose Level - _____) / Insulin Sensitivity Factor of _____ = Units of insulin
□ Correction dose scale (use instead of calculation above to determine insulin correction dose):

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<thead>
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<th>Blood Glucose</th>
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<th>mg/dL</th>
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□ Other Diabetes Medication/Dosage: ___________________________

Physician Signature ___________________________ Date ___________________________
Address ___________________________ Phone ___________________________