TRADERS POINT CHRISTIAN SCHOOLS

TRAINING SCHOLARS. MAKING DISCIPLES. GRADUATING LEADERS.

Diabetes Medical Action Plan

Student Name: _____ DOB: _____

Teacher/Grade: _____

Emergency Contacts:

	Name/Relationship:	Number:
a.	_____	_____
b.	_____	_____

Diagnosis:

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other_____

Checking blood glucose:

Brand/model of blood glucose meter:_____

Target range of blood glucose before meals:_____

Check blood glucose level:

☐ before breakfast ☐ after breakfast ☐ ____hours after breakfast ☐ 2 hours after a correction dose

☐ before lunch ☐ after lunch ☐ ____hours after lunch ☐ before dismissal

☐ mid-morning ☐ before PE ☐ after PE ☐ other_____

☐ as needed for signs/symptoms of hypo/hyperglycemia ☐ as needed for signs/symptoms of illness

Preferred testing site: ☐ side of fingertip _____ ☐ other_____

*The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

☐ independently checks own blood glucose

☐ may check blood glucose with supervision

☐ requires a school nurse or trained diabetes personnel to check blood glucose

☐ uses a smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM):☐ yes☐ no brand/model:_____

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CGM Alarms:

Severe low_____ Low_____ High_____

Predictive alarm low_____ Predictive alarm high_____

Rate of change low_____ Rate of change high_____

Threshold suspend setting:_____

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level.
- If student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do no disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. DO NOT THROW AWAY.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-care CGM skills	Independent?	
The student troubleshoots alarms and malfunctions.	☐ yes	☐ no
The student knows what to do and is able to deal with a HIGH alarm.	☐ yes	☐ no
The student knows what to do and is able to deal with a LOW alarm.	☐ yes	☐ no
The student can calibrate the CGM.	☐ yes	☐ no
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ yes	☐ no

The student should be escorted to the school nurse if the CGM alarm goes off:☐ yes ☐ no

Other instructions for the school health team: _____

_____

Hypoglycemia treatment:

Student's usual symptoms of hypoglycemia: _____

_____

_____

If exhibiting symptoms of hypoglycemia OR if blood glucose level is less than _____mg/dL, give a quick-acting glucose product equal to _____grams of carbohydrate.

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____mg/dL.

Additional treatment: _____

_____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having a seizure activity or convulsions (jerking movements):

- Position the student on his/her side to prevent choking.
- Give glucagon: ☐ 1mg ☐ ½ mg☐ other dose: _____
  - Route: ☐ subcutaneous (SC) ☐ intramuscular (IM)
  - Site for injection: ☐ buttocks ☐ arm ☐ thigh ☐ other: _____
- Call 911 and the student's parents/guardians
- Contact the student's healthcare provider

Hyperglycemia treatment:

Student's usual symptoms of hyperglycemia:_____

_____

_____

- Check☐ urine ☐ blood for ketones every ____ hours when blood glucose levels are above _____mg/dL.
- For blood glucose greater than _____mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _____mg/dL.
- For insulin pump users see: **Additional Information for Student with Insulin Pump**.
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.

Additional treatment for ketones: _____

If the student has symptoms of a hyperglycemia emergency, call 911 and contact the student's parents/guardians and healthcare provider. Symptoms of hyperglycemia emergency include: dry mouth, extreme thirst, nausea/vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

Insulin therapy:

Insulin delivery device: ☐ syringe ☐ insulin pen ☐ insulin pump

Type of insulin therapy at school: ☐ adjustable (basal-bolus) insulin ☐ fixed insulin therapy ☐ no insulin

Adjustable (basal-bolus) Insulin Therapy

- Carbohydrate coverage/correction dose and type of insulin: _____
- Insulin-to-carbohydrate ratio:
  - Breakfast: 1 unit of insulin per _____ grams of carbohydrate
  - Lunch: 1 unit of insulin per _____ grams of carbohydrate
  - Snack: 1 unit of insulin per _____ grams of carbohydrate

Correction Dose Calculation Example
$\frac{\text{Total Grams of Carbohydrate to be Eaten}}{\text{Insulin-to-Carbohydrate Ratio}}$ = _____ Units of Insulin

Correction dose: Blood glucose correction factor (insulin sensitivity factor) = ____ Target blood glucose = ____mg/dL

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Correction Dose Calculation Example
$\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Correction Factor}}$ = _____ Units of Insulin

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose _____ to _____ mg/dL, give _____units. Blood glucose _____ to _____ mg/dL, give _____ units.

Blood glucose _____ to _____ mg/dL, give _____ units. Blood glucose _____ to _____ mg/dL, give _____ units.

When to give insulin:

Breakfast

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____mg/dL and _____ hours since last insulin dose.

☐ Other: _____

Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____mg/dL and _____ hours since last insulin dose.

☐ Other: _____

Snack

☐ No coverage for snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____mg/dL and _____ hours since last insulin dose.

☐ Correction dose only for blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.

☐ Other: _____

Fixed Insulin Therapy

Name of insulin: _____

☐ _____ units of insulin given pre-breakfast daily

☐ _____ units of insulin given pre-lunch daily

☐ _____ units of insulin given pre-snack daily

☐ other: _____

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Parent/Guardian Authorization to Adjust Insulin Dose:

☐ Yes ☐ No Parent/Guardian authorization should be obtained before administering a correction dose.

☐ Yes ☐ No Parent/Guardian is authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.

☐ Yes ☐ No Parent/Guardian is authorized to increase or decrease insulin-to-carbohydrate ration within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate.

☐ Yes ☐ No Parent/Guardian is authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

Student's self-care insulin administration skills:

☐ Independently calculates and gives own injections.

☐ May calculate/give own injections with supervision.

☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

Additional information for student with insulin pump:

Brand/model of pump: _____ Type of insulin pump:_____

Basal rates during school:

Time:_____ Basal Rate:_____ Time:_____ Basal Rate:_____

Time:_____ Basal Rate:_____ Time:_____ Basal Rate:_____

Time:_____ Basal Rate:_____ Time:_____ Basal Rate:_____

Other pump instructions: _____

_____

Type of infusion set: _____

Appropriate infusion site(s): _____

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

☐ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.

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

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Physical Activity:

- May disconnect from pump for sports activities: ☐ Yes, for _____ hours ☐ No
- Set a temporary basal rate: ☐ Yes, _____ % temporary basal for _____ hours ☐ No
- Suspend pump use: ☐ Yes, for _____ hours ☐ No

Student's Self-Care Pump Skills	Independent?	
Counts carbohydrates	☐ yes	☐ no
Calculates correct amount of insulin for carbohydrate consumed	☐ yes	☐ no
Administers corrections bolus	☐ yes	☐ no
Calculates and sets basal profiles	☐ yes	☐ no
Calculates and sets temporary basal rate	☐ yes	☐ no
Changes batteries	☐ yes	☐ no
Disconnects pump	☐ yes	☐ no
Reconnects pump to infusion set	☐ yes	☐ no
Prepares reservoir, pod, and/or tubing	☐ yes	☐ no
Inserts infusion set	☐ yes	☐ no
Troubleshoots alarms and malfunctions	☐ yes	☐ no

Other diabetes medications:

Name: _____ Dose: _____ Route: _____ Time(s) given: _____

Name: _____ Dose: _____ Route: _____ Time(s) given: _____

Meal Plan:

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		_____ to _____
Mid-morning snack		_____ to _____
Lunch		_____ to _____
Mid-afternoon snack		_____ to _____

Other times to give snacks and content/amount: _____

_____

Instructions for when food is provided to the class (class party or food sampling): _____

_____

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

Student's self-care nutrition skills:

☐ Independently counts carbohydrates

☐ May count carbohydrates with supervision

☐ Requires school nurse/trained diabetes personnel to count carbohydrates

Physical activity and sports:

A quick-acting source of glucose such as ☐ glucose tabs and/or ☐ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat ☐ 15 grams ☐ 30 grams ☐ other: _____

☐ before ☐ every 30 minutes ☐ every 60 minutes ☐ after vigorous physical activity ☐ other: _____

If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

Disaster Plan:

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parent/guardian.

☐ Continue to follow orders contained in this Diabetes Medical Action Plan.

☐ Additional insulin orders as follows (e.g. dinner and nighttime): _____

_____

_____

☐ Other: _____

Signatures:

This Diabetes Medical Action Plan (DMAP) has been approved by:

Healthcare Provider Name:_____

Healthcare Provider Signature:_____ Date:_____

Healthcare Provider Phone: _____

I, (parent/guardian) _____, give permission to the school nurse or another qualified healthcare professional or trained diabetes personnel of Traders Point Christian Schools to perform and carry out the diabetes care tasks as outlined in this DMAP. I also consent to the release of the information contained in this DMAP to all school staff members and other adults who have responsibility for my child and who ay need to know this information to maintain my child's health and safety. I also give permission to the school nurse or other qualified healthcare professional to contact my child's healthcare provider.

Parent/Guardian Signature:_____ Date:_____

Reviewed by School Nurse:_____ Date:_____