TRADERS POINT CHRISTIAN SCHOOLS

(parents complete page 1 and Physicians review page 2 and complete and sign page 3)

DIABETIC Medical Action Plan (MAP)

Student's Name____

Date of birth______________ **Age**_____ **Grade**_____

Child's picture; face only

CONTACT INFORMATION

Call First(Parent/Guardian)	**Try Second(Parent/Guardian**
Name:	**Name:**
Relationship:	**Relationship:**
Home:	**Home:**
Cell:	**Cell:**
Work:	**Work:**

Call Third (If a parent/guardian cannot be reached)

Name:____ Relationship:___________________________________

Address:____

Phone:____

HISTORY AND MANAGEMENT

Age when diabetes was diagnosed:___________ Type 1 **YES NO** Type 2 **YES NO**

Can student perform their own blood glucose (BG) testing YES NO Please monitor/help YES NO
Will student have a glucometer for school use only? YES NO
Routinely test BG: Before snack Before lunch Before exercise After exercise Other:________________
Target BG range_______to_________

Insulin will be given at school YES NO IF YES, please circle: Syringe/vial Insulin Pen Pump
Can student given their own insulin or insulin bolus (if student on pump) YES NO Please monitor/help YES NO

Please send a copy home of all BG readings, carbohydrate and correction calculations with insulin given? YES NO
If YES, please circle how often: Weekly Monthly Other________________

Accommodations as needed will be allowed as necessary. The details of supply location (office, class, etc.), BG testing and daily planning are to be planned at each school Consider student's current ability, safety, ease of use and individual self-care preferences.
Other considerations/instructions:____

I agree to have the information in this plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having diabetes to better identify needs. I give permission to use my child's picture on this plan (if i did not supply a photo). I give permission to have trained staff to help administer the medication ordered for my child's asthma.and to contact the physician listed for clarification of orders, if needed.

Date:____________________________ Signature:____

Signs of Hypoglycemia or Low Blood Glucose (Sugar)

- Hunger or dizzy
- Shakiness or weakness
- Sweating or pale
- Personality or behavior changes
- Other:___________________
- Blood glucose under 65 or 80 with symptoms

Common causes (can happen quickly)

- Loss of consciousness
- Seizure
- Inability to swallow

ACTIONS:

- Stay with the student. Never send anywhere alone.
- Check BG if possible. If not treat for low BG
- Give 15 gms of fast acting carbohydrate (4 oz juice or chew 3-4 glucose tablets, or consume other sugar source.
- Keep student in Nurses office and recheck BG after 15 minutes.
- Repeat 15 gms of carbs if BG under 65 or __________
- Follow with protein snack if more than an hour before next meal/snack.
- Notify parent/guardian.

Signs of EMERGENCY:

- Loss of consciousness
- Seizure
- Inability to swallow

ACTION:

- Call 911: do not give anything by mouth
- Trained person to give Glucagon (if ordered)
- Position on left side (if possible)
- Stay with student
- Notify parent/guardian

Signs of Hyperglycemia or High Blood Glucose

- Thirst or Hunger
- Frequent Urination
- Fatigue or Sleepiness
- Dry warm skin
- Blurred vision or Poor concentration
- Other___________________
- Blood Glucose over 300

Common Causes (happens slowly, hours to days)

- Too little insulin
- Too much food
- Decreased activity
- Illness or stress (hormones)

ACTION:

Check urine for ketones:

- Ketones large or moderate (see Emergency below)
- Ketones negative, trace or small:
  - Give water or sugar free drink(8 oz q hr)
  - For small ketones, recheck after one hr
  - Notify parent/guardian
  - If unable to check ketones and BG >300 and student feels ok, offer water and call parent/guardian
  - Recheck BG in 1 hr
  - If unable to check ketones and student is symptomatic with BG>300, rest, water while awaiting parent/guardian

Signs of EMERGENCY

- Moderate to Large Ketones
- Nausea or Vomiting or Abdominal pain
- Sweet, fruity breath
- Labored breathing
- Confused or Unconscious

ACTION

- Call 911 if student is unresponsive
- Call 911 if abdominal pain, nausea, vomiting or lethargic AND parent/guardian can't be reached
- No water if vomiting
- No exercise

Authorized Physician Order/Licensed Prescriber & Agreement with Protocol in this 2 page plan (see page 1)

Insulin____________________Carb ratio___________________ Correction factor_________________________

Target Blood Sugar_______________Changes in insulin calculation to be determined by parent/guardian **YES NO**

Glucagon YES NO (*please circle correct dose)* **Dose** 1mg (entire vial) or **Dose** ½ mg (half of vial)
Give as injection (mix first) into leg or arm muscle for severe hypoglycemia with unconsciousness or inability to swallow. Refer to package directions if needed for further help.

Other instructions/orders____
____

Physician/Licensed Prescriber______________________Phone__________________Fax_____________

Signature____