DIABETES ACTION PLAN FORM

This coversheet is ONLY for the form and student listed above and MUST BE RECEIVED for processing.

DO NOT use staples or paperclips!

Please print and complete this form then submit all pages including this coversheet via:

<table>
<thead>
<tr>
<th>FAX</th>
<th>MAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>(877) 447-9530</td>
<td>Magnus Health</td>
</tr>
<tr>
<td>Outside of the United States? Please fax to (978) 244-8894</td>
<td>Attn: Student Medical Records</td>
</tr>
<tr>
<td></td>
<td>514 Daniels Street #367</td>
</tr>
<tr>
<td></td>
<td>Raleigh, NC 27605</td>
</tr>
</tbody>
</table>
Diabetes Medical Management Plan

Effective Dates: ____________________________

This plan should be completed by the student’s personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Student’s Name: ____________________________

Date of Birth: ________________ Date of Diabetes Diagnosis: ________________

Grade: ____________________________ Homeroom Teacher: ____________________________

Physical Condition:  □ Diabetes type 1 □ Diabetes type 2

Contact Information

Mother/Guardian: ____________________________

Address: ______________________________________

Telephone: Home_________________ Work ________________ Cell ________________

Father/Guardian: ____________________________

Address: ______________________________________

Telephone: Home_________________ Work ________________ Cell ________________

Student’s Doctor/Health Care Provider:

Name: ____________________________

Address: ______________________________________

Telephone: ____________________________ Emergency Number: ____________________________

Other Emergency Contacts:

Name: ____________________________

Relationship: ____________________________

Telephone: Home_________________ Work ________________ Cell ________________

Notify parents/guardian or emergency contact in the following situations:

_________________________________________

_________________________________________
**Blood Glucose Monitoring**

Target range for blood glucose is  
- 70-150  
- 70-180  
- Other

Usual times to check blood glucose

Times to do extra blood glucose checks (check all that apply)
- before exercise
- after exercise
- when student exhibits symptoms of hyperglycemia
- when student exhibits symptoms of hypoglycemia
- other (explain):

Can student perform own blood glucose checks?  
- Yes  
- No

Exceptions:

Type of blood glucose meter student uses:

---

**Insulin**

**Usual Lunchtime Dose**

Base dose of Humalog/Novolog/Regular insulin at lunch (circle type of rapid-/short-acting insulin used) is  
- units or does flexible dosing using  
- units/  
- grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente  
- units or  
basal/Lantus/Ultralente  
units.

**Insulin Correction Doses**

Parental authorization should be obtained before administering a correction dose for high blood glucose levels.  
- Yes  
- No

- units if blood glucose is  
- to  
- mg/dl

- units if blood glucose is  
- to  
- mg/dl

- units if blood glucose is  
- to  
- mg/dl

- units if blood glucose is  
- to  
- mg/dl

- units if blood glucose is  
- to  
- mg/dl

Can student give own injections?  
- Yes  
- No
Can student determine correct amount of insulin?  
- Yes  
- No
Can student draw correct dose of insulin?  
- Yes  
- No

Parents are authorized to adjust the insulin dosage under the following circumstances:________________

---

**For Students With Insulin Pumps**

Type of pump:  
Basal rates:  
- 12 am to  
-  
- to  
- to  

Type of insulin in pump:  

Type of infusion set:  

Insulin/carbohydrate ratio:  
Correction factor:  

---

50  Helping the Student with Diabetes Succeed

Excerpted from: Helping the Student with Diabetes Succeed: A Guide for School Personnel. Published by National Diabetes Education Program: A Joint Program of the National Institutes of Health and the Centers for Disease Control and Prevention
### Student Pump Abilities/Skills:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Needs Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count carbohydrates</td>
<td>✗ Yes  ✗ No</td>
</tr>
<tr>
<td>Bolus correct amount for carbohydrates consumed</td>
<td>✗ Yes  ✗ No</td>
</tr>
<tr>
<td>Calculate and administer corrective bolus</td>
<td>✗ Yes  ✗ No</td>
</tr>
<tr>
<td>Calculate and set basal profiles</td>
<td>✗ Yes  ✗ No</td>
</tr>
<tr>
<td>Calculate and set temporary basal rate</td>
<td>✗ Yes  ✗ No</td>
</tr>
<tr>
<td>Disconnect pump</td>
<td>✗ Yes  ✗ No</td>
</tr>
<tr>
<td>Reconnect pump at infusion set</td>
<td>✗ Yes  ✗ No</td>
</tr>
<tr>
<td>Prepare reservoir and tubing</td>
<td>✗ Yes  ✗ No</td>
</tr>
<tr>
<td>Insert infusion set</td>
<td>✗ Yes  ✗ No</td>
</tr>
<tr>
<td>Troubleshoot alarms and malfunctions</td>
<td>✗ Yes  ✗ No</td>
</tr>
</tbody>
</table>

### For Students Taking Oral Diabetes Medications

<table>
<thead>
<tr>
<th>Type of medication:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other medications:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing:</td>
<td></td>
</tr>
</tbody>
</table>

### Meals and Snacks Eaten at School

<table>
<thead>
<tr>
<th>Meal/ Snack</th>
<th>Time</th>
<th>Food content/amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-morning snack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-afternoon snack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dinner</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Snack before exercise? | ✗ Yes  ✗ No |
| Snack after exercise?  | ✗ Yes  ✗ No |

Other times to give snacks and content/amount: __________________________

Preferred snack foods: __________________________

Foods to avoid, if any: __________________________

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

______________________________

### Exercise and Sports

A fast-acting carbohydrate such as ________________________________ should be available at the site of exercise or sports.

Restrictions on activity, if any: ________________________________

Student should not exercise if blood glucose level is below _________mg/dl or above _________mg/dl or if moderate to large urine ketones are present.
Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: ____________________________________________

Treatment of hypoglycemia: ________________________________________________

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. Route_______, Dosage_______, site for glucagon injection: _______arm, _______thigh, _______other. If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia: ____________________________________________

Treatment of hyperglycemia: ________________________________________________

Urine should be checked for ketones when blood glucose levels are above _________ mg/dl. Treatment for ketones: ____________________________________________

Supplies to be Kept at School

- Blood glucose meter, blood glucose test strips, batteries for meter
- Lancet device, lancets, gloves, etc.
- Urine ketone strips
- Insulin vials and syringes
- Insulin pump and supplies
- Insulin pen, pen needles, insulin cartridges
- Fast-acting source of glucose
- Carbohydrate containing snack
- Glucagon emergency kit

Signatures

This Diabetes Medical Management Plan has been approved by:

Student’s Physician/Health Care Provider ___________________________ Date _____________

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of __________________________ school to perform and carry out the diabetes care tasks as outlined by __________________________’s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child’s health and safety.

Acknowledged and received by:

Student’s Parent/Guardian ___________________________ Date _____________

Student’s Parent/Guardian ___________________________ Date _____________