



Bellevue Public Schools

B

NRS 1033-3/23

Diabetes Action Plan

Please complete this form with current information about your student's diabetes plan. A new action plan is required each school year to be completed on or after May 1. **If the plan changes during the school year, provide the information to the health office in writing.**

Student information

Student's name _____ Date of Birth _____
School _____ Grade _____
Date of diabetes diagnosis _____ Type 1 _____ Type 2 _____
Has the student lost consciousness, experienced a seizure, or required glucagon? Yes _____ No _____
If yes, date of last event _____
Has the student been admitted for DKA after diagnosis? Yes _____ No _____
If yes, date of last event _____

Contact information

Parent/Guardian 1 _____
Telephone Home _____ Work _____ Cell _____
Email address _____

Parent/Guardian 2 _____
Telephone Home _____ Work _____ Cell _____
Email address _____

Student's physician/health care provider _____
Address _____
Telephone _____ Fax _____

Supplies Required at School

Blood glucose meter, blood glucose test strips, batteries for meter, lancet device, lancets, alcohol wipes, ketone strips, insulin (vial or pen), syringes or pen needles, fact-acting source of glucose, carbohydrate snack and glucagon emergency kit.

For students with an insulin pump, additional required equipment includes: extra pump set and batteries.

The parent/guardian is responsible for providing and maintaining supplies and calibrating equipment.

Location of supplies while at school _____

Blood Glucose Monitoring

Brand/model of blood glucose meter _____

Target range of blood glucose _____

Check blood glucose level

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Before breakfast | <input type="checkbox"/> After breakfast | <input type="checkbox"/> _____ Hours after breakfast | <input type="checkbox"/> 2 hrs after correction dose |
| <input type="checkbox"/> Before lunch | <input type="checkbox"/> After lunch | <input type="checkbox"/> _____ Hours after lunch | <input type="checkbox"/> Before dismissal |
| <input type="checkbox"/> Mid-morning | <input type="checkbox"/> Before PE | <input type="checkbox"/> After PE | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> As needed for signs/symptoms of low or high blood glucose | | | <input type="checkbox"/> As needed for signs/symptoms of illness |

Student's 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
- ☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM) ☐ Yes ☐ No Brand/model _____

Alarms set for Severe Low _____ Low _____ High _____

CGM may be used for insulin dosing ☐ Yes ☐ No

Other instructions _____

Student's CGM skills Check "Yes" or "No" if the student can perform the skill independently.

- | | | |
|--|------------------------------|-----------------------------|
| The student troubleshoots alarms and malfunctions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The student knows what to do for a HIGH alarm | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The student knows what to do for a LOW alarm | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The student can calibrate the CGM | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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 Name of insulin _____

Carbohydrate Coverage

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

Carbohydrate Dose Calculation Example

Total Grams of Carbohydrate to Be Eaten ÷ Insulin-to-Carbohydrate Ratio = _____ Units of Insulin

Correction Dose Blood glucose correction factor (insulin sensitivity factor) = _____
Target blood glucose = _____ mg/dL

Correction Dose Calculation Example

(Current Blood Glucose – Target Blood Glucose) ÷ 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: _____

Other diabetes medications

Name: _____ Dose: _____ Route: _____ Times given: _____

Name: _____ Dose: _____ Route: _____ Times given: _____

Student's 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 student can give own injection 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 in pump _____

Basal rates during school	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 parents/guardians.
- ☐ 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.

Student's insulin pump skills Check "Yes" or "No" if the student can perform the skill independently

Counts carbohydrates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates correct amount of insulin for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Administers correction bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes batteries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnects pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnects pump to infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepares reservoir, pod, and/or tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inserts infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoots alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Meal Plan

<i>Meal/Snack</i>	<i>Time</i>	<i>Carbohydrate Content (grams)</i>
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 (e.g., as part of a class party) _____		

Student's nutrition skills

- ☐ Independently counts carbohydrates
☐ May count carbohydrates with supervision
☐ Requires school nurse/trained diabetes personnel to count carbohydrate

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 of carbohydrate ☐ 30 grams of carbohydrate ☐ other _____
☐ before ☐ every 30 minutes during ☐ every 60 minutes during ☐ 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

☐ trace ☐ small ☐ moderate ☐ large

Physical Activity for students using an insulin pump

May disconnect from pump for sports activities	<input type="checkbox"/> Yes, for _____ hours _____	<input type="checkbox"/> No
Set a temporary basal rate	<input type="checkbox"/> Yes, _____ % temporary basal for _____ hours	<input type="checkbox"/> No
Suspend pump use	<input type="checkbox"/> Yes, for _____ hours _____	<input type="checkbox"/> No

Hypoglycemia treatment

Student's usual symptoms of hypoglycemia (list below)

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.

Notify parents/guardians if blood glucose is below _____ mg/dL.

Additional treatment

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

- Position the student on his or her side to prevent choking.
- Administer glucagon Name of glucagon used _____

Injection

☐ 1 mg ☐ ½ mg ☐ Other (dose) _____
Route ☐ Subcutaneous (SC) ☐ Intramuscular (IM)

Nasal route

- ☐ 3 mg
- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- If on insulin pump, stop by placing mode in suspend or disconnect. Always send pump with EMS to hospital.

Hyperglycemia treatment

Student's usual symptoms of hyperglycemia (list below)

- 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 (Emergency Medical Services) and contact the student's parents/guardians. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

Signatures

This Diabetes Medical Management Plan has been approved by

Student's Physician/Health Care Provider

Date

I, (parent/guardian) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of Bellevue Public Schools to perform and carry out the diabetes care tasks as outlined in (student name) _____'s Diabetes Action Plan. I also consent to the release of the information contained in this Diabetes Action Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by

Student's Parent/Guardian

Date

School Nurse/Other Qualified Health Care Personnel

Date