Diabetic Action Plan

Student Name:_____ Date:_____
Teacher:_____ Grade:____Age:_____
Parents Name:_____Home Phone:_____
Mom's Cell:_____Dad's Cell_____
Physician's Name:_____Phone:_____

Management Plan During School

Type of Insulin:_____
Route of administration:_____
Dosage ratio (carb count: units insulin) _____
Time to be given:_____
In the event of low blood sugar the procedure at school is: to give some form of sugar or carbs such as crackers or a ½ carton milk or juice. If the student is unconscious, call 911. Call parent/guardian.

Goal: To keep blood sugar between_____and _____mg/dl.
Correction guidelines:_____

_____.

A) . **The student's blood sugar will be checked prior to lunch every day and at any other time deemed necessary.**
B) **The student needs assistance with the following diabetic care tasks:_____.**
C) **The student is able to perform the following tasks with out help:_____.**

Emergency Items Provided By Parent:
(please date and initial)

Glucose tablets_____ Glucometer_____
Snacks_____ Insulin_____
Glucagon_____ Syringes_____

I approve the above plan as written:
Parent signature_____ Date_____.
Rev. diabetic action plan 2008-09