HS0024
Rev. 7/22

DIABETES INFORMATION ACTION PLAN

Health Services Department
Lincoln Public Schools • Lincoln, Nebraska

Student Name: _____ ID#: _____ Grade: _____

We request that you complete, sign, and return this form to the school health office annually if the condition named above affects your student.

- This information is important to keeping your student safe, and providing correct emergency response, at school.
- It is a prioity for us to have current emergency contact information for you.
- Written authorization from your student's licensed medical provider is required for medically necessary cares at school (if any are needed, including medications). **A new authorization is required for each school year and/or when medical orders change**.
- The school nurse may contact you or your licensed medical provider for additional information or clarification on medication administration and cares at school.
- Information will be shared as appropriate with other school personnel to benefit your student's safety and educational success at school.
- Self-Management of Diabetes and/or the carrying of medications requires additional consents. Contact your school nurse.
- If you have questions, please contact the school nurse at your student's school.

Date of Diabetes Diagnosis: _____ ❑ Diabetes Type I ❑ Diabetes Type II

Parent/Guardian Name: _____ Phone (#1): _____

Home Address: _____ Phone (#2): _____

Parent/Guardian Name: _____ Phone (#1): _____

Home Address: _____ Phone (#2): _____

Emergency Phone Contact #1: _____ _____ _____
Name *Relationship* *Phone*

Emergency Phone Contact #2: _____ _____ _____
Name *Relationship* *Phone*

Medical Providers: _____ Phone: _____

_____ Phone: _____

_____ Phone: _____

HYPOGLYCEMIA MANAGEMENT *(Low Blood Sugar)*

Signs of Hypoglycemia:

Treatment of Hypoglycemia (specify blood sugar ranges as needed):

❑ Glucagon is to be Administered Under the Following Circumstances:

Note: If glucagon is administered, 911 and parents/guardian will be summoned to the school.

HYPERGLYCEMIA MANAGEMENT *(High Blood Sugar)*

Signs of Hyperglycemia:

Treatment of Hyperglycemia (specify blood sugar ranges as needed):

❑ Urine or Blood Ketones Should be Checked with the following symptoms _____

or when blood glucose levels are above _____ mg/dl.

BLOOD GLUCOSE MONITORING

Target Range: _____

Preferred School Location for Performing Blood Glucose Tests: _____

Type of Glucometer Used by Student: _____

EXERCISE AND SPORTS

❑ Restrictions on Activity, if any: _____

❑ Student Should Not Participate if Blood Glucose is Below _____ mg/dl.

❑ Student Should Not Participate if Moderate to Large Ketones are Present at School (if tested).

MEALS AND SNACKS AT SCHOOL

❑ Snack Foods, Fast-Acting Carbohydrate, or free snacks such as _____ are Provided by the Parent/Guardian.

Location: _____

❑ Instructions When Food is Provided to the Class:

❑ Instructions for Field Trips:

❑ Student May Carry a Fast-Acting Carbohydrate Such as _____ for Self-Care.

NOTE: Parents are responsible to provide snacks.

SCHOOL EMERGENCY & SAFETY PLAN

❑ Provide extra snacks for the classroom.

❑ Provide extra supplies for classroom.

MEDICATIONS

ORAL MEDICATIONS

Name of Medication: _____ Dose: _____ Time: _____

INJECTABLE INSULIN *(All insulin must be replaced every 28 days.)*

Name of Insulin: _____ Method of Injection: _____

Changes in Insulin Doses Required in Writing from Parent/Guardian or Licensed Medical Provider, Email OK.

Other Injectable Medications (if applicable): _____

❑ Insulin Correction/Sliding Scale for Blood Glucose Reading:

_____ units of _____ if blood glucose is _____ to _____ mg/dl

_____ units of _____ if blood glucose is _____ to _____ mg/dl

_____ units of _____ if blood glucose is _____ to _____ mg/dl

_____ units of _____ if blood glucose is _____ to _____ mg/dl

❑ Adjust Insulin Dose to Carbohydrate for School **Breakfast** Intake Using:

_____ Units of Insulin per _____ Grams of Carbohydrate.

❑ Adjust Insulin Dose to Carbohydrate for School **Lunch** Intake Using:

_____ Units of Insulin per _____ Grams of Carbohydrate.

Maximum Bolus Dose of Insulin _____ Units (if applicable).

INSULIN PUMP USERS *(Complete insulin correction/sliding scale above in the event of pump malfunction.) Health Office Staff Do Not Change Basal Rates on Pumps.*

How Long Has Your Student Had an Insulin Pump: _____

Type of Pump: _____ Type of Insulin in Pump: _____

Maximum Bolus Setting: _____

DIABETES MEDICAL MANAGEMENT PLAN

START DATE	TIME	GLUCOSE TESTING	SNACK OR MEAL	INSULIN ADMINISTERED

❑ Notify parent if BS is less than _____ or greater than _____

❑ If Glucagon is ordered by your doctor, do you choose to provide the medication to the school? ❑ Yes ❑ No

❑ If you provide Glucagon to the school, do you want LPS Health Staff to accompany your student on field trips and school activities during instructional hours? ❑ Yes ❑ No

❑ Nurse/Parent/Guardian/Student Review LPS Diabetics Checklist

❑ Troubleshoot Alarms and Malfunction on Pump

This space is for any individualized information about your student that you wish to share:

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

School Nurse: _____ Date: _____