

DIABETES MEDICAL ACTION PLAN

CHILD, YOUTH & SCHOOL SERVICES

FORT LEONARD WOOD

(Must be completed by a licensed health professional)

CYS Services staff are not permitted to administer glucagon or insulin. Glucagon can be stored at the CYS Services facility, but only parent (s) or EMS personnel called to the care site are permitted to administer it.

Child's Name	Date of Birth	Child's Grade
Effective Dates of Plan	Type of Diabetes <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Diabetes Type 2	Date of Diabetes Diagnosis
Sponsor's Name and Contact information Name: Cell: Work: Home:	Spouse's Name and Contact Information Name: Cell: Work: Home:	Child's Health Care Provider and Contact Information Name: Cell: Work: Emergency:

Symptoms of Low Blood Sugar Shakiness Pale or flushed face Sweaty Confused Looks dazed Weak "feels hungry" "feels low" Headache Other: _____	Plan of Action for Low Blood Sugar 1 If blood sugar is _____ to _____, do nothing, this is in the normal range 2 If blood sugar is _____ to _____, give snack _____: a. Notify Parent b. Recheck blood sugar in _____ minutes, continue to follow number's 1 and 2.	<b style="color: red;">EMERGENCY • <b style="color: red;">If blood sugar is less than _____ CALL 911 and notify parent If child is conscious, instant glucose should be given ORALLY. Name: _____ Amount: _____
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Symptoms of High Blood Sugar Inability to concentrate Frequent thirst Frequent urination Nausea Stomach ache Heavy breathing Combative behavior/personality Other: _____	Plan of Action for High Blood Sugar 1 If blood sugar is between _____ and _____, do nothing, this is in the normal range 2 If blood sugar is _____ to _____: a. encourage sugar-free noncaloric fluids (water, diet soda, Crystal Light) b. Notify parent c. Recheck blood sugar in _____ minutes and continue to follow numbers 1 and 2. • If blood sugar is above _____ notify parent to pick up child (child may need insulin)	<b style="color: red;">EMERGENCY <b style="color: red;">If blood sugar is above _____ CALL 911 and notify parent
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<b style="text-align: center;">Blood Glucose Monitoring Target range for blood glucose is _____ to _____. Usual time to check blood glucose _____. Times extra blood glucose checks are needed (check all that apply): <input type="checkbox"/> Before exercise <input type="checkbox"/> After exercise <input type="checkbox"/> When child exhibits symptoms of low blood sugar <input type="checkbox"/> When child exhibits symptoms of high blood sugar <input type="checkbox"/> Other: _____	Can child perform own blood glucose checks: <input type="checkbox"/> YES <input type="checkbox"/> NO Exceptions: _____ _____ _____ Type of blood glucose meter used: _____
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Children with Insulin Pumps

Type of pump _____

Basal rates: _____ 12 am to _____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

CYS Services will relay history of blood sugar testing to parent by telephone and obtain instruction from parent on corrective insulin bolus indicated. CYS Services will review instruction with child and observe to ensure child accurately programs pump to administer correct dose (when age appropriate). All actions will be detailed on the daily log.

Meals and Snacks Eaten While in CYS Services Programs

Is child independent in carbohydrate calculations and management: _____ YES _____ NO

If "NO" parent will provide all carbohydrate calculations which will be based upon current CYS Services menus.

Snack before exercise? _____ YES _____ NO

Snack after exercise? _____ YES _____ NO

Meal/Snack	Time	Food content/amount
Breakfast	_____	_____
Mid-morning Snack	_____	_____
Lunch	_____	_____
Mid-Afternoon Snack	_____	_____
Dinner	_____	_____

Other times to give snacks and content/amount: _____

Prepared 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 sugar level is below _____ or above _____.

Supplies to be kept at CYS Services (3 day supply)

_____ Blood glucose meter, blood glucose test strips, batteries for meter _____ Lancet device, lancets, gloves, alcohol pads, etc

_____ Fast acting source of glucose _____ Carbohydrate containing snack

_____ Glucagon emergency kit

Type/Print Name of Parent	Signature of Parent /Date
Stamp of Licensed Health Care Professional	Signature of Licensed Health Care Professional/Date
Printed Name/Stamp of Army Public Health Nurse	Signature of Army Public Health Nurse/Date
This signature serves as the exception to medication policy	