CATOOSA COUNTY PUBLIC SCHOOLS
DIABETES ACTION PLAN

School_____**School Year** _____**Date** _____

Student Name: _____ **Date of Birth:** _____
Teacher: _____ **Grade Level:** _____
Parents / Guardian: _____
Home Phone: _____ **Work Phone (Mother):**_____
Cell Phone: _____ **Work Phone (Father):** _____

Emergency Contact: _____
Name Relationship Phone
Emergency Contact: _____
Name Relationship Phone
Primary Physician: _____

I understand that it is my responsibility as the parent / guardian of _____ to notify the school nurse / designee of any changes in my child's health condition and/or medication / treatment regimen. I authorize my child's physician and his/her staff to release the following information regarding my child's health condition. I understand that this health information will ONLY be shared with pertinent school staff.

_____ _____
Parent/Guardian Signature Date

COMPLETED BY PHYSICIAN:

TYPE OF DIABETES: _____

- **Has child been hospitalized in the past year for Diabetes?** _____
- **If yes, when?** _____
- **How will this illness impact school attendance?** _____

CURRENT INSULIN REGIMEN:

	Type	Dose	Time
Morning			
Lunch			
Dinner			
Bedtime			

- **Will student require Insulin at school?** Yes ◯ No ⊙
- **Can student give his / her own Insulin?** Yes ◯ No ⊙
- **Will student need supervision in giving his / her own Insulin?** Yes ◯ No ⊙

PUMP INFORMATION:

_____
_____
_____

BLOOD GLUCOSE MONITORING:

- **Target range of blood glucose:** _____ **mg/dl to** _____ **mg/dl**
- **Will student require routine glucose monitoring at school?** Yes ☐ No ☐
- **Can student test his/her own blood glucose level?** Yes ☐ No ☐
- **Will student require supervision with blood glucose monitoring?** Yes ☐ No ☐
- **Will student require supplemental testing time?**
  - ☐ **Before exercise**
  - ☐ **After exercise**
  - ☐ **Before snack(s)**
  - ☐ **With symptoms of high/low**
  - ☐ **Other:** _____
- **Does student check urine for glucose?** Yes ☐ No ☐
- **Will student need assistance with urine testing?** Yes ☐ No ☐
- **Routine time for urine testing:** _____

Student: _____

DIETARY GUIDELINES:

- **Estimated Calories per Day:** _____
- **Meal / Snack Times:**
  - **Breakfast @** _____ **a.m.**
  - **Snack @** _____ **a.m.**
  - **Lunch @** _____ **a.m.**
  - **Snack @** _____ **a.m.**
  - **Supper @** _____ **a.m.**
  - **Bedtime @** _____ **a.m.**

- **Will student need to be reminded to take a snack?** **Yes** ☐ **No** ☐
- **Modifications for (classroom) parties:** _____
  _____

PHYSICAL ACTIVITY:

- **Does student have restrictions regarding physical activity?** **Yes** ☐ **No** ☐
- **Describe:** _____
  _____
  _____
- **Is snack required before physical activity?** **Yes** ☐ **No** ☐
- **Snack given before activity if:** _____
- **Exercise should be delayed or avoided if the blood is higher than** _____ **mg/dl and lower than** _____ **mg/dl**

EMERGENCIES SERVICES FOR SCHOOL:

HYPOGLYCEMIA – Insulin Reaction

- **How often do hypoglycemic reactions occur?** _____
- **When is the usual time of day hypoglycemic reactions occur?** _____
- **Student's symptoms:** _____
- **Treatment:** _____
  _____
  _____

HYPERGLYCEMIA – High Blood Glucose

- **How often do hyperglycemic reactions occur?** _____
- **When is the usual time of day hyperglycemic reactions occur?** _____
- **Student's symptoms:** _____
- **Treatment:** _____
  _____
  _____

_____ _____

Physician Signature **Date**