

Brenham ISD Athletic Training

Diabetes Action Plan

Student Name (Nombre): _____ Date of Birth _____

Parent/Guardian (Padre/Tutor): _____ Phone (Teléfono) _____

Parent/Guardian (Padre/Tutor): _____ Phone (Teléfono) _____

Emergency Phone Contact (Telefónico)

#1 _____

Name (Nombre)	Relationship (Parentesco)	Phone (Teléfono)
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#2 _____

Name (Nombre)	Relationship (Parentesco)	Phone (Teléfono)
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*****Physician use only*****

Physician Name (Nombre): _____ Phone(Teléfono) _____

Address (Dirección): _____

Notify parents/guardian or emergency contact in the following situations:

Blood Glucose Monitoring

Target range for blood glucose is 70-150 70-180 Other _____

Usual times to check blood glucose:

- Before am snack Before lunch Before PE
 2 hours after a correction dose For Suspected hypoglycemia/hyperglycemia

Times to do extra blood glucose checks (check all that apply)

- Before exercise After exercise
 Other (explain) _____

Can student perform own blood glucose checks? Yes No

Exceptions: _____

Type of blood glucose meter student uses: _____

Insulin

Brand of insulin _____

Give _____ units of _____ insulin SQ at _____ time.

Give _____ units of _____ insulin SQ at _____ time.

Insulin dose based on carbohydrate intake: Give _____ units SQ per _____ gms of carbohydrates at lunch.

Correction factor: At lunchtime give _____ units of insulin SQ for every _____ mg/dl above _____ mg/dl.

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Insulin Correction Doses

Parental authorization should be obtained before administering a correction dose for high blood glucose levels Yes No

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

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

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

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

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

Parents are authorized to adjust the insulin dosage under the following circumstances:

Student ability/Skills

Can student give own injections? Yes No

Can student determine correct amount of insulin? Yes No

Can student draw correct dose of insulin? Yes No

Insulin Pumps

Type of pump: _____ Type of insulin in pump: _____

Type of infusion set: _____

Bolus Administration times: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Additional orders: _____

Student Pump Abilities/Skills: Needs Assistance

Count carbohydrates Yes No

Bolus correct amount for carbohydrates consumed Yes No

Calculate and administer corrective bolus Yes No

Calculate and set basal profiles Yes No

Calculate and set temporary basal rate Yes No

Disconnect pump Yes No

Reconnect pump at infusion set Yes No

Prepare reservoir and tubing Yes No

Insert infusion set Yes No

Troubleshoot alarms and malfunctions Yes No

Students Taking Oral Diabetes Medications

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

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Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? Yes No

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

Snack before exercise? Yes No

Snack after exercise? Yes No

Other times to give snacks and content/amount:

Preferred 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 glucose level is below _____ mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

Additional Instructions:

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____

Treatment of hypoglycemia: _____

Glucagon should be given if the student's blood sugar is _____ mg/dl or is unconscious, having a seizure (convulsion), or unable to swallow.

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Route _____, Dosage _____, site for glucagon injection: _____ arm, _____ thigh, _____ other.

If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

Additional physician orders:

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia: _____

Treatment of hyperglycemia: _____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____

Supplies to be Kept at School

_____ Blood glucose meter, blood glucose test strips, batteries for meter

_____ Lancet device, lancets, gloves, etc.

_____ Urine ketone strips

_____ Insulin pump and supplies

_____ Insulin pen, pen needles, insulin cartridges

_____ Fast-acting source of glucose

_____ Carbohydrate containing snack

_____ Glucagon emergency kit

Additional supplies needed _____

Signatures

This Diabetes Medical Management Plan has been approved by:

_____ Date

Student's Physician/Health Care Provider

Date

I give permission to the school nurse, athletic trainer,, trained diabetes personnel, and other designated staff members of Brenham ISD to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

_____ Date

Student's Parent/Guardian

Date

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Student's Parent/Guardian

Date