DIABETES INFORMATION ACTION PLAN
Raymond Central Public Schools

Student Name: _____ 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 priority 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 an*d*/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.

Parent/Guardian Name & Phone #1: _____

Parent/Guardian Name & Phone #2: _____

Emergency Phone Contact #1 *(Name, Relationship, Phone)* _____

Emergency Phone Contact #2 *(Name, Relationship, Phone)* _____

Medical Providers: _____

Office Information: _____

Parent Signature: _____

HYPOGLYCEMIA MANAGEMENT

Signs of Hypoglycemia:

Treatment of Hypoglycemia (specify lows):

*** Glucagon will be administered if the child is unconscious and unresponsive. If glucagon is administered, 911 and parents/guardian will be summoned to the school. ***

HYPERGLYCEMA MANAGEMENT

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:

Notify Parent When Blood Sugar Ranges are:

Device Used to Check Blood Sugar.

Preferred School Location for Performing Blood Glucose Tests:

Times of Blood Sugar Testing:

Will student carry their own supplies? **YES** **NO**
If yes, please list (may need a self-carry consent):

EXERCISE AND SPORTS
Restrictions on Activity, if any:

Check Blood Glucose Before and After PE or Sports Activities:

YES **NO**

Student Should Not Participate if Blood Glucose ls 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, East-Acting Carbohydrates, are Provided by the Parent/Guardian
Location of snacks:

Instructions When Food is provided to the Class:

Instructions for Field Trips:

MEDICATIONS
ORAL MEDICATIONS:

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.
☐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

***Notify School nurse if new insulin to carb ratio.**

Current Insulin Dosing Equation and Ratio:

INSULIN PUMP USERS
***Health Office Staff Will 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: