

**Biloxi Public Schools**  
**Diabetes History and Action Plan**  
**\*To be completed by healthcare provider\***

**Student's Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Grade** \_\_\_\_\_

Diabetes Type 1 \_\_\_\_\_ Diabetes Type 2 \_\_\_\_\_ Hypoglycemia \_\_\_\_\_

**CURRENT MEDICATION PROFILE**

Drug Name: \_\_\_\_\_ Amount: \_\_\_\_\_ How Often: \_\_\_\_\_

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**BLOOD GLUCOSE MONITORING:**

Target range for blood glucose: \_\_\_\_\_ Usual times to check blood glucose: \_\_\_\_\_

Can student perform own blood glucose checks? \_\_\_\_\_yes \_\_\_\_\_no

**INSULIN:**

Insulin/Carbohydrate ratio: \_\_\_\_\_ Correction Factor: \_\_\_\_\_

Insulin correction dose at school:

\_\_\_\_\_ Units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

\_\_\_\_\_ Units if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

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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

**MEALS AND SNACKS EATEN AT SCHOOL:**

Is student independent in carbohydrate calculations and management? \_\_\_\_\_yes \_\_\_\_\_no

Does student require scheduled snacks during school day? \_\_\_\_\_yes \_\_\_\_\_no

If yes, times for snacks \_\_\_\_\_ amount of carbs \_\_\_\_\_

**EXERCISE AND SPORTS:**

Parent/guardian must provide all snacks for diabetic emergencies. Student should not exercise if blood glucose level is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl . Other sports/exercise instructions \_\_\_\_\_.

**STUDENTS WITH INSULIN PUMPS:**

Type of pump: \_\_\_\_\_ Basal Rate: \_\_\_\_\_

Type of insulin in pump: \_\_\_\_\_

Insulin/Carbohydrate ratio: \_\_\_\_\_ Correction Factor: \_\_\_\_\_

Student pump abilities/skills:

Count carbohydrates	_____	yes	_____	no
Bolus correct amount for carbs consumed	_____	yes	_____	no
Calculate and administer corrective bolus	_____	yes	_____	no
Disconnect pump	_____	yes	_____	no
Reconnect pump at infusion site	_____	yes	_____	no
Prepare reservoir and tubing	_____	yes	_____	no
Insert infusion set	_____	yes	_____	no
Troubleshoot alarms and malfunctions	_____	yes	_____	no

**SUPPLIES TO BE KEPT AT SCHOOL:**

\_\_\_\_\_ Blood glucose meter, blood glucose strips, batteries for meter

\_\_\_\_\_ Lancet device, lancets

\_\_\_\_\_ Insulin pen, pen needles

\_\_\_\_\_ Insulin vials and syringes

\_\_\_\_\_ Carbohydrate containing snacks

\_\_\_\_\_ Insulin pump and supplies

\_\_\_\_\_ Urine ketone strips

\_\_\_\_\_ Fast acting source of glucose

\_\_\_\_\_ Glucagon emergency kit (must complete medication form)

**HYPOGLYCEMIA:**

Usual symptoms of hypoglycemia \_\_\_\_\_

\_\_\_\_\_

Treatment of hypoglycemia \_\_\_\_\_

\_\_\_\_\_

**HYPERGLYCEMIA:**

Usual symptoms of hyperglycemia: \_\_\_\_\_

Treatment of hyperglycemia: \_\_\_\_\_

\_\_\_\_\_

Ketones should be checked when blood glucose level is above \_\_\_\_\_

Treatment for ketones \_\_\_\_\_

\_\_\_\_\_

**EMERGENCY CONTACTS:**

1. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

2. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

3. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**IF UNABLE TO CONTACT PARENT/GUARDIAN WITH NUMBER LISTED ABOVE WITHIN A REASONABLE AMOUNT OF TIME 911 WILL BE CALLED!**

\_\_\_\_\_

Prescriber's signature

Date

\_\_\_\_\_

Prescriber's printed name

\_\_\_\_\_

Prescriber's contact information

**I agree with this plan**

\_\_\_\_\_

Parent's Signature

Date