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:_____

Drug Name:_____ Amount:_____ ____How Often:_____

Drug Name:_____ Amount:_____ ____How Often:_____

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

_____Units if blood glucose is_____to_____mg/dl

_____Units if blood glucose is_____to_____mg/dl

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