



Pediatric Type 2 Diabetes *Action Plan*



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This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of plan: _____ This plan is valid for the current school year: _____ – _____

Student Information

Student's name: _____ Date of birth: _____

Date of diabetes diagnosis: _____ Type 2 Other: _____

School: _____ School phone number: _____

Grade: _____ Homeroom teacher: _____

School nurse: _____ Phone: _____

Contact Information

Parent/guardian 1: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Parent/guardian 2: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Student's physician/health care provider: _____

Address: _____

Telephone: _____ Emergency number: _____

Email address: _____

Other emergency contacts:

Name: _____ Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Checking blood glucose

Brand/model of blood glucose meter: _____

Target range of blood glucose:

Before meals: 90–130 mg/dL Other: _____

Check blood glucose level:

- Before breakfast After breakfast ____ Hours after breakfast
 Before lunch After lunch ____ Hours after lunch
 Mid-morning Before PE After PE Other: _____
 As needed for signs/symptoms of low or high blood glucose As needed for signs/symptoms of illness

Preferred site of testing: Side of fingertip Other: _____

Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

- Independently checks own blood glucose
 May check blood glucose with supervision
 Requires a school nurse or trained diabetes personnel to check blood glucose
 Uses a smartphone or other monitoring technology to track blood glucose values

Hypoglycemia treatment

Student's usual symptoms of hypoglycemia (list below):

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment: _____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- Position the student on his or her side to prevent choking.
- Give glucagon: 1 mg ½ mg Other (dose) _____
 - Route: Subcutaneous (SC) Intramuscular (IM)
 - Site for glucagon injection: Buttocks Arm Thigh Other: _____
- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Contact the student's health care provider.

Hyperglycemia treatment

Student's usual symptoms of hypoglycemia (list below):

- Check Urine Blood for ketones every ____ hours when blood glucose levels are above _____ mg/dL.
- For blood glucose greater than _____ mg/dL AND at least ____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _____ mg/dL.
- For insulin pump users: see **Additional Information for Student with Insulin Pump**.
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.

Additional treatment for ketones: _____

- Follow physical activity and sports orders. (See **Physical Activity and Sports**)

If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

Insulin Therapy

Insulin delivery device: Syringe Insulin pen Insulin pump

Type of insulin therapy at school: Adjustable (basal-bolus) insulin Fixed insulin therapy No insulin

When to give insulin:

Breakfast

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and ____ hours since last insulin dose.
- Other: _____

Lunch

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and ____ hours since last insulin dose.
- Other: _____

Snack

- No coverage for snack
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and ____ hours since last insulin dose.
- Correction dose only: For blood glucose greater than _____ mg/dL AND at least ____ hours since last insulin dose.
- Other: _____

Insulin Therapy *(continued)*

Fixed Insulin Therapy

Name of insulin: _____

_____ Units of insulin given pre-breakfast daily

_____ Units of insulin given pre-lunch daily

_____ Units of insulin given pre-snack daily

Other: _____

Parents/Guardians Authorization to Adjust Insulin Dose

Yes No Parents/guardians authorization should be obtained before administering a correction dose.

Yes No Parents/guardians are authorized to increase or decrease correction dose scale within the following range:
+/- _____ units of insulin.

Yes No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate.

Yes No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range:
+/- _____ units of insulin.

Student's self-care insulin administration skills:

Independently calculates and gives own injections.

May calculate/give own injections with supervision.

Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.

Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

Other diabetes medications

Name: _____ Dose: _____ Route: _____ Times given: _____

Name: _____ Dose: _____ Route: _____ Times given: _____

Meal plan

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		_____ to _____
Mid-morning snack		_____ to _____
Lunch		_____ to _____
Mid-afternoon snack		_____ to _____

Other times to give snacks and content/amount:

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

Meal plan *(continued)*

Special event/party food permitted: Parents'/Guardians' discretion Student discretion

Student's self-care nutrition skills:

- Independently counts carbohydrates
- May count carbohydrates with supervision
- Requires school nurse/trained diabetes personnel to count carbohydrates

Physical activity and sports

A quick-acting source of glucose such as glucose tabs and/or sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat 15 grams 30 grams of carbohydrate other: _____

before every 30 minutes during every 60 minutes during after vigorous physical activity

other: _____

If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

(See **Administer Insulin** for additional information for students on insulin pumps.)

Disaster plan

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

- Continue to follow orders contained in this DMMP.
- Additional insulin orders as follows (e.g., dinner and nighttime):

Other: _____

Signatures

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider

Date

I, (parent/guardian) _____, give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) _____

to perform and carry out the diabetes care tasks as outlined in (student) _____

Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian

Date

School Nurse/Other Qualified Health Care Personnel

Date