TRI-TOWN DIABETES ACTION PLAN

Directions: If the participant has diabetes, please complete this form and submit it with your program registration paperwork.

Participant's Full Name:____

Only medications which are prescribed by a physician and which are essential for the participant to remain at program shall be given.

Diagnosis:____________________ **Medication Name:**____________________

Dosage:____________________ **Route of Administration:**____________________

Time/Circumstances when Medication Should Be Administered:____________________

____

Side Effects:____

Special Instructions:____

Date of Prescription:____

May the student self-carry/self-administer (asthma medication only) ☐Yes ☐No ☐Not Applicable

I. DIABETES INFORMATION

Hyperglycemia (High Blood Sugar) ***Not enough insulin in the body to allow sugar to be used***	**Hypoglycemia (Low Blood Sugar)** ***Usually happens before lunch or after exercise***
Possible Symptoms: Excessive Thirst — Excessive Hunger Flushed Dry Skin — Breath Fruity Odor Frequent Urination — Fatigue Tired — Weakness Blurred Vision — Vomiting	**Possible Symptoms:** Weakness/Fatigue — Excessive Hunger Feeling Faint — Abdominal Pain Dizziness — Confusion Shaky/Trembling — Anxious/Irritable Nausea — Sweaty/Pallor Rapid Pulse — Slurred Speech

FIRST AID FOR HIGH OR LOW BLOOD SUGAR

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

1. Check the blood sugar if signs & symptoms occur.
2. Check urine for ketones, if Blood Sugar is above __________
3. Stay with child continuously.
4. Provide water to drink, allow unlimited use of bathroom
5. Call parent/guardian if any of the following:
   Blood sugar is above ______________
   Ketones are ☐ Moderate or ☐ High
   Experiencing nausea/vomiting
6. Administer insulin per physician's order (see Medication Authorization)
7. Recheck blood sugar in ________ minutes and at _______ minute intervals
8. Call 9-1-1 if:
   -Participant loses consciousness
   -Unable to reach parent/guardian and symptoms worsen
9. Stay with child continuously

ADDITIONAL PUMP INSTRUCTIONS

-Check pump function, pump site, and tubing
-Treat for Hyperglycemia as above

PARENT INITIALS: ________

Additional Information

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HYPOGLYCEMIA (LOW BLOOD SUGAR)

1. Check the blood sugar if signs & symptoms occur.
2. Stay with the participant continuously.
3. Give the carbohydrate supplement ordered by the physician if blood sugar is less than ___________ and participant is conscious, cooperative and able to swallow.
   - Give _______ grams carbohydrate
   - Examples: ______________________________
4. Check blood sugar after 15 minutes.
   - If blood sugar does not improve, give fast sugar again.
   - When symptoms improve, provide an additional snack of ______________________________
5. Call 9-1-1, the parents, and the participant's physician, if:
   - Symptoms do not subside
   - Participant loses consciousness
   - Unable to reach parent and symptoms worsen
6. Give Glucagon _______mg injection if child is unconscious, experiencing a seizure or unable to swallow and place student on side.
7. When conscious and able to swallow 4 oz. of juice may be given until EMS arrives.

ADDITIONAL PUMP INSTRUCTIONS

-Check pump function, pump site, and tubing
-Treat for Hypoglycemia as above

PARENT INITIALS: ________

Additional Information

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II. DIABETES MANAGEMENT AT TRI-TOWN YMCA

Blood Glucose Monitoring	Target Blood Sugar Range: ______________ mg/dl to ________________ mg/dl Usual Times to Check Blood Sugar: Before Snack Before Lunch Before Physical Activities After Physical Activities Can the participant check their own blood sugar: □ Yes □ No Can the participant check their own ketones: □ Yes □ No
Insulin	Does the participant require assistance with carbohydrate counting? □ Yes □ No Can the participant give their own injections and/or operate pump? □ Yes □ No Types of Insulin Taken: ________________________ □ Pen □ Pump □ Injection Usual Times of Insulin Injections: _______________ Basal Rate, if on Pump: ________ Amount of Insulin to Give: _____________________ If sliding scale, physician order necessary
Giving Insulin With their pump, does the participant know how to: Change tubing □ Yes □ No Change batteries □ Yes □ No change insulin cartridge □ Yes □ No Decide bolus amount □ Yes □ No Give bolus □ Yes □ No	1. Using the glucose meter, check the blood sugar. 2. Document the blood sugar in the log book and notify parent/guardian as indicated under first aid for hypo/hyperglycemia on front of this document. 3. Administer insulin using the following calculations (sliding scale plus ratio amount): **Units of Insulin to Give Based on Sliding Scale of Blood Sugar Reading** **PLUS** **Insulin/Carbohydrate Ratio** Blood Sugar 150-200 = ____Units Ratio: _____ Units insulin per _____ Carbs Blood Sugar 201-250 = ____Units Blood Sugar 251-300 = ____Units Blood Sugar 301-350 = ____Units Blood Sugar 351-400 = ____Units Blood Sugar >401 = ____Units *****IF GREATER THAN _____ CALL PARENT & DOCTOR*****
Qualified Y Staff (Completed by Y)	Staff qualified to use glucose meter: ________________________________ Staff qualified to give insulin injections and/or operate pump: ________________________________
Supply Location	Diabetes Care Supplies Are Kept: ____________________ Supplies of Snack Foods Are Kept: ____________________ Additional (emergency) Supplies Are Kept: ______________

FOOD & EXERCISE

Meals/Snacks	Time	Food Content/Amount	Preferred Snacks
Breakfast	______	______________	______________
Mid-Morning	______	______________	______________
Lunch	______	______________	
Mid-Afternoon	______	______________	**Foods to Avoid**
Before Exercise	______	______________	______________
After Exercise	______	______________	______________
Other	______	______________	______________

Participant should not exercise if blood sugar is below ______ mg/dl OR above ______ mg/dl.
Other exercise instructions or physical activity restrictions/limitations/accommodations:

Physician's Order & Signature	This diabetic management plan has been approved by: ________________________ ____________to____________ **Physician's Signature** **Effective Date**
Parent/Guardian Signature	This diabetic management plan has been approved by: ________________________ ______________ **Parent/Guardian Signature** **Date**