

Student Name: \_\_\_\_\_

Student's  
photo

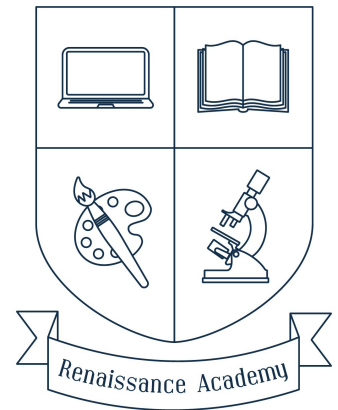
### Renaissance Academy DIABETES Medical Action Plan (MAP)

**Date of Birth**  
**Age                      Grade                      School Year**

Page one of this MAP is to be completed, signed and dated by a parent/guardian.  
Page two of this MAP is to be completed, signed and dated by the treating physician or licensed prescriber.

**Without signatures this MAP is not valid.**

**The parent/guardian is responsible for supplying all medications and any other needed equipment/supplies to Renaissance Academy (RA).**



#### CONTACT INFORMATION

	<u>Call First</u>	<u>Try Second</u>
Parent/ Guardian:	Name: _____	Name: _____
	Relationship: _____	Relationship: _____
Phone:	Home: _____	Home: _____
	Cell: _____	Cell: _____
	Work: _____	Work: _____

**Call Third** (If a parent /guardian cannot be reached)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

#### HISTORY and MANAGEMENT

Age when diabetes was diagnosed \_\_\_\_\_ Insulin dependent diabetes (Type I)    YES    NO

Can student perform their own blood glucose (BG) testing    YES    NO    Please monitor/help    YES    NO

Will student have a glucometer for RA use only    YES    NO

Routinely test BG:    Before Snack    Before Lunch    Before Exercise    After Exercise    Other \_\_\_\_\_

Target BG range \_\_\_\_\_ to \_\_\_\_\_

Insulin will be given at school    YES    NO    If YES, please circle: Syringe/vial    Insulin pen    Pump

Can student give their own insulin or insulin bolus, if on pump    YES    NO    Please monitor/help    YES    NO

Please send a copy home of all BS readings, carbohydrate & correction calculations, with insulin given    YES    NO If

YES, please circle how often: Weekly    Monthly    Other \_\_\_\_\_

**Other considerations/instructions:**

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having diabetes to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to help administer and/or monitor all the medication or testing required/ordered in this two page plan as needed for control of blood sugar and to contact the ordering prescriber for clarification of orders if needed.

Date \_\_\_\_\_ Parent/Guardian \_\_\_\_\_  
*Signature*

**Signs of Hypoglycemia or Low Blood Sugar (BS)**

- Hunger or dizzy
- Shakiness or weakness
- Sweating or pale
- Personality or behavior change
- Other \_\_\_\_\_
- Blood sugar under 65 or **80 with symptoms**



**\*Common Causes\*** (can happen quickly)

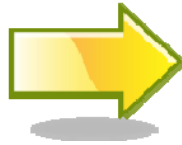
- Too much insulin
- Missed or delayed food
- Intense Exercise

**ACTION**

- Stay with the student. Never send alone anywhere.
- Check blood sugar (BS) if possible. If not, treat for a low BS.
- Give 15 grams of fast acting carbohydrate (4oz juice, or chew 3-4 glucose tablets, or consume other sugar source.)
- Wait 15 minutes & re-check BS.
- Repeat treatment of 15 grams of carbohydrate if BS is under 65 or \_\_\_\_\_
- If more than one hour before the next meal or snack, give a snack of carbohydrate and protein now (i.e. cheese & crackers.)
- Notify parent/guardian. Be sure student feels okay before returning to normal activity.
- Other \_\_\_\_\_

**Signs of EMERGENCY**

- Loss of consciousness
- Seizure
- Inability to swallow



**ACTION**

- Call 911; Do Not give anything by mouth
- Trained person to give Glucagon (if ordered)
- Position on side (if possible); Stay with child
- Notify parent/guardian

**Signs of Hyperglycemia or High Blood Sugar (BS)**

- Thirst or Hunger
- Frequent urination
- Fatigue or Sleepiness
- Dry warm skin
- Blurred vision or Poor concentration
- Other \_\_\_\_\_
- Blood sugar over 300



**\*Common Causes\*** (happens slowly, hours to days)

- Too little insulin
- Too much food
- Decreased activity
- Illness or stress (hormones)

**ACTION**

Check urine for ketones:

- 9 Ketones Moderate or Large (see EMERGENCY below)
- 9 Ketones Negative, Trace or Small, go to next bullet
- Give water or sugar free drink (8 oz every hour)
- For Small ketones, recheck after one hour or at next urination Notify parent/guardian
- No exercise if ketones are present
- If unable to test for ketones and student has no symptoms (feels ok but BS is >300) Offer water & call family
- May Return to class or rest per student's desires
- Recheck BS in one hour if unable to reach family
- If unable to test for ketones and student is having symptoms (feels bad with BS>300) Encourage water, rest and continue to monitor until parents can be reached.

**Signs of EMERGENCY**

- Moderate to Large Ketones
- Nausea or Vomiting or Abdominal pain
- Sweet, fruity breath
- Labored breathing
- Confused or Unconscious



**ACTION**

- Call 911 if student is unresponsive
- Call parent/guardian and encourage water
- Call 911 if abdominal pain, nausea, vomiting or lethargic AND parent/guardian can't be reached
- No water if vomiting
- No exercise

**Authorized Physician Order/Licensed Prescriber & Agreement with Protocol in this 2 page plan**

Insulin \_\_\_\_\_ Carb Ratio \_\_\_\_\_ Correction Factor \_\_\_\_\_ Target BS \_\_\_\_\_

Continuous Glucose Monitor (CGM) YES NO

Changes in insulin calculation to be determined by parent/guardian YES NO

Glucagon YES NO (please circle correct dose) Dose 1mg (entire vial) or Dose ½ mg (half of vial)

Give as injection (mix first) into leg muscle for severe hypoglycemia with unconsciousness, seizures, or inability to swallow.

Other instructions/orders \_\_\_\_\_

Physician/Licensed Prescriber \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_