Student Name _____ Attachment D

OXFORD COMMUNITY SCHOOLS
WHERE THE GLOBE IS OUR CAMPUS

Child's picture

Oxford Community Schools
Diabetes Medical Action Plan (MAP)

Student's Name_____
Date of Birth _____ **School** _____
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 a physician/licensed prescriber.
Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all medications ordered and any other supplies necessary to this plan of action.

Transportation Office Use ONLY if needed
Bus #
Driver:
Route #
Medical File

CONTACT INFORMATION

	Call First	Try Second
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 school 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_____

Accommodations as needed will be allowed. The details of supply location (such as office, locker, classroom, self-carry) are to be decided at each school. Consider the student's current ability, safety, ease of use and individual self-care preferences.

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:

- Ketones Moderate or Large (see EMERGENCY below)
- 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**_____