LEXINGTON CHRISTIAN ACADEMY

DIABETES ACTION PLAN 2024-2025 SCHOOL YEAR

Parents must complete and submit the **DIABETES ACTION PLAN** to authorize Lexington Christian Academy (LCA) personnel. Parents must update the form prior to each year the student is attending LCA. For your reference, LCA's Medical Guidelines can be found on the back of this Diabetes Action Plan.

STUDENT INFORMATION

Name: _____

DOB: _____ **Grade:** _____

Emergency Contact: _____

Emergency Contact Cell Phone #: _____

FAMILY INFORMATION

Mother/Guardian: _____

Mother/Guardian Cell #: _____

Father/Guardian: _____

Father/Guardian Cell #: _____

STUDENT SELF-CARE – PLEASE SELECT ALL THAT APPLY:

___ Totally independent management
___ Test blood sugar independently
___ Tests and interprets urine/blood ketones
___ Administers insulin independently
___ Self-injects with verification of dose
___ Self-injects mild hypoglycemia
___ Monitors own snacks and meals
___ Counts carbohydrates independently
___ Self-injects with trained staff supervision
___ Injections to be done by trained staff

I authorize LCA to notify me via the following methods:

___ Voice mail or text to cell phone #: _____ **___ Email at:** _____

PARENT SIGNATURE: _____ **DATE:** _____

MEDICAL INFORMATION TO BE COMPLETED BY PHYSICIAN

#1 – BLOOD SUGAR CHECKS

Target Blood Sugar Range _____ to _____

Select one: ____ Student can perform checks independently OR

____ Requires school nurse assistance

Check all that apply for time to check BG:

___ Before lunch ___ After snack ___ As needed for signs of low or high blood sugar

___ After lunch ___ Before P.E. ___ Other: _____

___ Before snack ___ After P.E.

#2 – INSULIN ADMINISTRATION

Insulin administered by: ___ Pen ___ Syringe ___ Pump

Type of Insulin: ___ Humalog ___ Novolog ___ Regular

Other:_____

Meals and snacks: ___ units for every ___ grams of carbohydrates eaten

Correction Dose?

___ NO

___ Yes please select one of the following:

___ Units for every __ mg/dl points above ___mg/dl

___ BOLUS per pump recommendations

__ If checked, use Dexcom G6/G5 readings to dose insulin. Glucometer Type / Brand: _____

If signs/symptoms do not match Dexcom readings, perform finger stick blood sugar test. Supplies/glucometer will be kept: ___ In the nurse's office ___ With the student

 # 3 – HYPOGLCEMIA – BLOOD SUGAR LESS THAN ____ MG/DL
Symptoms of hypoglycemia: dizziness, shaking, anxiety, hunger, blurry vision, weakness/fatigue, headache, behavior changes, pallor, loss of consciousness, seizure.

This student may also exhibit: _____

If a student presents with symptoms check BG. If BG level is below _____, treat with _____ grams of fast acting sugar (glucose tabs, juice or snack provided by the school nurse.) Recheck BG in 15 minutes; treat again until BG is greater than _____.

SEVERE HYPOGLYCEMIA: BG BELOW ____

Indications for use of Glucagon: unconsciousness, drowsiness, inability to swallow by mouth.

Administer **GLUCAGON**: _____ mg/IM/SQ/Intranasal. **CALL 911 and notify parent.**

#4 – HYPERGLYCEMIA – BLOOD SUGAR GREAT THAN ___ MG/DL
Symptoms of hyperglycemia: increased thirst, frequent urination, hunger, fatigue, irritability, double vision, nausea/vomiting, abdominal pain.

This student may also exhibit: _____

If a student presents with symptoms check BG. If BG level is over _____ mg/DL and it has been greater than _____ hours since the last insulin dose.
* Give insulin per sliding scale/BOLUS per pump recommendations.
* Give 8-16 oz. of water per hour.
* Recheck BG in two hours and treat with sliding scale insulin as needed.
* When having symptoms of nausea/vomiting, students will be released from school to parent/guardian.

Check ketones if BG is over _____ mg/DL for _____ hours. **If ketones are present, notify the parent/guardian**.

When student has insulin pump:
*Blood sugar greater than 300mg/DL with ketones or two consecutive unexplained blood sugars greater than 300mg/DL (with our without ketones,) may indicate a malfunction with the pump.
*Student may require insulin via injection and/or new infusion site. **PARENTS MUST BE NOTIFIED.**

Physician's Name: _____ **Phone #:** _____

Physician's Signature: _____ **Date:** _____

ALL MEDICATION WILL BE DISCARED IF NOT PICKED UP BY MAY 31, 2025. THE ABOVE MEDICATION ORDER IS VALID FOR ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.

MEDICATION GUIDELINES

The administration of medication to students shall be done only in exceptional circumstances where the student's health may be jeopardized without it. Whenever possible, administration of medication should be done at home. (Medication prescribed three times per day can be given before school, after school, and at bedtime.) If a new medication is started, the first dose must be given at home, unless it is a rescue medication.

The school will adhere to the following guidelines as it pertains to medication:

1) Administration of prescription medication by school personnel must only be done according to the written order of a licensed prescriber and written authorization of parent / guardian and Licensed School Nurse, regardless of the student's age.

- Mixed dosages in a single container will not be accepted for administration at school.
- If a half tablet is required for a correct dosage, it is the parent's / guardian's responsibility to provide pre-cut tablets for administration at school.
- Altered forms of medication will not be accepted or administered at school.
- Narcotics / medical cannabis will not be administered at school.
- Aspirin-containing products will not be administered at school.

2) All medication (prescription and non-prescription) must be brought to and from school by a parent / guardian in its original container. The following information must be on the prescribed container label:

- Student's full name
- Name and dosage of medication
- Time and directions for administration at school
- Licensed prescriber's name
- Date (must be current)

3) New consent from a licensed health care provider and parent / guardian signatures must be received each school year.

4) A new medication consent form is required when the medication dosage or time of administration is changed.

5) When a long-term daily medication is stopped, a written physician / licensed prescriber's order is requested.