

**CLOVIS MUNICIPAL SCHOOLS
DIABETES ACTION PLAN**

STUDENT NAME: _____ GRADE/CLASS: _____

We are providing you with this plan to help faculty and school nurse work with your child's physicians in controlling his/her diabetes at school. This plan will be kept in an accessible location at the school.

IN AN EMERGENCY, CONTACT:

Parent/Guardian: _____ Relationship: _____

Phone: (H) _____ (W) _____ (C) _____ (Pager) _____

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Phone: (H) _____ (W) _____ (C) _____ (Pager) _____

1. How old was this child when he/she was diagnosed with diabetes? _____

2. When was he/she **LAST** hospitalized for high/low blood sugar? _____

3. Who is the child's Physician? _____

4. Is this child currently taking medication for diabetes? (please list medications, time and dosages: _____

5. Child's usual symptoms for high blood sugar includes: _____

 **How high is too high? _____ What to do? _____

6. Child's usual symptoms for low blood sugar includes: _____

 **How low is too low? _____ What to do? _____

7. How often is child's blood sugar monitored? (times) _____

8. Do you ever need supplies? _____

9. What are the dietary limits? _____

10. **WHEN DO WE CALL 911?** _____

Doctor Signature

Date

Parent Signature

Date