

CYS SERVICES SNAP DIABETES MEDICAL ACTION PLAN

(to be completed by Health Care Provider)

NOTE TO HEALTH CARE PROVIDER: CYS staff/providers **CANNOT** administer insulin/glucagon injection, adjust insulin pumps and/or count carbohydrates.
Staff/providers **CAN** perform blood glucose checks, keep food diary/log and administer oral agents, i.e. glucose jell, orange juice

Child/Youth's Name	Date of Birth	Date
Sponsor Name		
Health Care Provider		Health Care Provider Phone

Hypoglycemia (Low Blood Sugar) Symptoms

- | | |
|---|---|
| <input type="checkbox"/> Shakiness | <input type="checkbox"/> Weak |
| <input type="checkbox"/> Pale or flushed face | <input type="checkbox"/> "Feels hungry" |
| <input type="checkbox"/> Sweaty | <input type="checkbox"/> "Feels low" |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Looks dazed | <input type="checkbox"/> Other: _____ |

Treatment of Hypoglycemia (CYS Staff/providers are NOT authorized to give injections, but will monitor those children who self administer)

- If blood sugar is _____ to _____, then do nothing; this is in the normal range.
- If blood sugar is less than _____, and child can speak or swallow, then give snack of _____, then check sugar in _____ minutes.
- If blood sugar is less than _____ then call parent/guardian.

EMERGENCY RESPONSE

- If blood sugar is less than _____, then **CALL 911** and call parent/guardian.
- Additional instructions (to include the use of oral rescue medications):

Hyperglycemia (High Blood Sugar) Symptoms

- | | |
|--|---|
| <input type="checkbox"/> Unable to concentrate | <input type="checkbox"/> Stomach ache |
| <input type="checkbox"/> Frequent thirst | <input type="checkbox"/> Heavy breathing |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Combative behavior/personality changes |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Other: _____ |

Treatment of Hyperglycemia

- If blood sugar is _____ to _____, then do nothing; this is in the normal range.
- If blood sugar is above _____, then notify parent/guardian.

EMERGENCY RESPONSE

- If blood sugar is above _____, then **CALL 911** and notify parent/guardian.
- Additional Instructions:

Follow Up

This Diabetes Medical Action Plan must be updated/revised whenever medications or child/youth's health status changes. If there are no changes, the Diabetes Medical Action Plan must be updated at least every 12 months.

Name _____

DIABETES MEDICAL ACTION PLAN ADDITIONAL CONSIDERATIONS

(to be completed by Health Care Provider)

Field Trip Procedures (CYS staff/providers are NOT authorized to give injections, but will monitor those children who self administer)

- Oral rescue medications should accompany child during any off-site activities.
- The child/youth should remain with staff or parent/guardian during the entire field trip: Yes No
- Staff/providers on trip must be trained regarding rescue medication use and this health care plan.
- This plan must accompany the child on the field trip.
- Other: (specify) _____

Self Medication for School Age Youth

- YES** Youth can self medicate. I have instructed _____ in the proper way to use His/her medication. It is my professional opinion that he/she **SHOULD** be allowed to carry and self administer his/her medication. Youth have been instructed not to share medications and should youth violate these restrictions, the privilege of self medicating will be revoked and the youth's parents notified. Youth are required to notify staff when carrying medication.
- NO** It is my professional opinion that _____ **SHOULD NOT** carry or self administer his/her medication.

Bus Transportation should be Alerted to Child/Youth's Condition.

- This child/youth carries rescue medications on the bus. Yes No
- Rescue medications can be found in: Backpack Waist pack On Person Other: _____
- Child/youth will sit at the front of the bus. Yes No
- Other: _____

Sports Events/Instructional Programs

Parents are responsible for having rescue medication on hand and administering it when necessary when the child/youth is participating in any CYS sports/instructional activity. Volunteer coaches/instructors do not administer medications.

Parental Permission/Consent

Parent's signature gives permission for child/youth personnel who have been trained in medication administration by the APHN to administer prescribed medicine and to contact emergency medical services if necessary. I also understand my child/youth must have required medication with him/her at all times when in attendance at CYS programs. **Parent must be readily available via telephone in the event of a diabetic emergency.**

Youth Statement of Understanding

I have been instructed on the proper way to use my medication. I understand that I may not share medications and should I violate these restrictions, my privileges may be restricted or revoked, my parents will be notified and further disciplinary action may be taken. I am also required to notify staff when carrying or taking my medication.

I agree with the plan outlined above.

Printed Name of Parent/Guardian	Parent/Guardian Signature	Date (YYYYMMDD)
Printed Name of Youth, if applicable	Youth Signature	Date (YYYYMMDD)
Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)
Printed Name of Army Public Health Nurse	Army Public Health Nurse Signature	Date (YYYYMMDD)
	(This signature serves as the exception to medication policy)	