PILOT - CYS SERVICES DIABETES DAILY MEDICAL ACTION PLAN

(Form to be completed by Health Care Provider)

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

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Program; DoDD 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; AR 608-10, Child Development Services.

PRINCIPAL PURPOSE: Information will be used to assist Army activities in their responsibilities in overall execution of the Army's Exceptional Family Member Program (EFMP) and the Army Child and Youth Services Program.

ROUTINE USES: The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system.

DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided individual may not be able to participate in Army Child and Youth Services Program.

In order to ensure the child/youth can be accommodated in a safe and healthy manner into a group child care setting, this plan should be completed by the child's health care provider in coordination with the CYS Services child/youth center's health consultant/Army Public Health Nurse (APHN) and the parent(s)/guardian(s). This plan should be developed with the understanding that child caregivers (non-medical personnel) responsible for caring for children in a group setting may be performing the tasks ordered on this Diabetes Daily Medical Action Plan. APHN Contact Information: ___________________________

Date of Diabetes Diagnosis:________________ (DAY/MONTH/YEAR) □ Type1 □ Type 2 □ other: ____________

Normal blood glucose range for child/youth: _______________ to _______________

DAILY CARE REQUIREMENTS (required during child care hours)

□ Food Monitoring □ Blood Glucose Monitoring □ Activity Monitoring □ Insulin Therapy

□ Other: ____

Storage of Diabetic Supplies and Emergency Response Medications (all supplies and medications supplied by parent/guardian)

□ Blood Glucose Meter & Test Strips □ Ketone Meter & Test Strips □ Lancets □ Glucagon □ Insulin Pen □ Insulin Vial & Syringe

FOOD MONITORING - OVERSIGHT BY STAFF

□ Meal/Snack Portion Control
- □ Verification of serving size
- □ Verification of amount of food consumed

□ Documentation on Food Log

□ Verification of accuracy of counting of carbohydrates

□ Verification of carb data entry into insulin pump

□Other: ____________________________

BLOOD GLUCOSE MONITORING

Check blood glucose: □ Before Meals/Snacks □ _________ Hours After Meals/Snacks

□ Before Activity □ After Activity □ Prior to leaving care

BLOOD GLUCOSE MONITORING – METER, LANCETS AND TEST STRIPS / CONTINUOUS GLUCOSE METER

□ **Yes** - Brand/Model of the blood glucose meter: _________________________________

Preferred testing site: □ Fingertips □ Forearm □ Thigh □ Other: ____________________

Note: If severely low blood glucose (hypoglycemia) is suspected only use the fingertips to check blood glucose.

□ **No -** Child/Youth has a Continuous Glucose Meter (CGM) - Brand/Model: __________________________________

Alarms set for: Low: ___________________ (mg/dl) High: ___________________ (mg/dl)

□ Take action based on alarms and readings

□ Confirm CGM results with a finger stick check before taking action based on CGM blood glucose readings.

Note: If child/youth has symptoms or signs of hypoglycemia, check finger stick blood glucose level regardless of CGM readings.

BLOOD GLUCOSE MONITORING – CHILD/YOUTH SELF-ADMINISTERING/MONITORING

□ **No -** CYSS Caregivers will need to perform and monitor blood glucose/ketone checks

□ **Yes with assistance**, child/youth can perform and self-monitor blood glucose/ketone checks with CYSS staff assistance

□ **Yes independently**, child/youth can independently perform and self-monitor blood glucose/ketone checks and can alert CYSS staff if assistance is required

□ **Child/Youth** has permission to carry self-monitoring items (meter, lancets, and test strips) and can responsibly maintain and dispose of lancets

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INSULIN THERAPY – CHILD/YOUTH OVERSIGHT BY STAFF

Given by: □ Insulin Pump □ Syringe & Vial □ Insulin Pen

Administered by : □ Child/Youth □ Parent □ Other: ___________________

Preferred Injection Site: □ Stomach □ Upper Arm □ Thigh □ Buttocks □ Rotation □ Other: _____________________

Note: For rotation of injection sites, please ensure all preferred sites are selected.

Symptomatic Blood Glucose Level Insulin Dosing: Give insulin according to the dosing scale:

Blood glucose _________ to __________ mg/dl give ____________ units of insulin

Blood glucose _________ to __________ mg/dl give ____________ units of insulin

Blood glucose _________ to __________ mg/dl give ____________ units of insulin

Post-meal dosing of insulin is preferred. Age and maturity must be considered when determining whether pre-meal dosing is appropriate for the child in a child care setting. Insulin dosing based on carbohydrate counts will only be supported for scheduled meals and snacks:

□ Meal provided by parent/guardian pre-labeled amount of carbohydrates. □ Army CYS Standardized Menu with Nutritional Data (check availability)

□ **Carbohydrate coverage only**: 1 unit of insulin per ____ grams of carbohydrate

□ **Carbohydrate coverage + correction factor dose**: Pre-meal blood glucose greater than ____ mg/dl (target blood glucose) and ___ hours since last insulin dose. Correction Factor: 1 unit of insulin per ____ mg/dl above target blood glucose + 1 unit of insulin per ____ grams of carbohydrate

□ **Insulin Pump Wizard**

□ DO NOT give insulin for snacks.

□ Other: ____

Child/Youth can determine own insulin dosages:

□ **No -** Parent/Guardian or authorized adult designee must determine dosage and administer insulin injections.

□ **Yes with assistance**, child/youth can determine dosage and administer insulin with supervision.

□ **Yes independently**, child/youth can independently determine dosage and administer insulin without assistance or supervision.

INSULIN PUMP:

Brand/Model: ________________________________ Type of Insulin: _____________________

For blood glucose greater than _______________ mg/dl for __________hours call parents/guardian for pickup.

Follow actions and emergency protocols for signs/symptoms of low or high blood glucose (hypoglycemia/hyperglycemia).

Child/Youth can self-manage their insulin pump:

□ **No -** Parent/Guardian or authorized adult designee must assist child/youth to manage insulin pump settings.

□ **Yes with assistance**, child/youth can self-manage their insulin pump but may need CYSS staff to oversee entering blood sugar and meal information.

□ **Yes independently**, child/youth can independently manage their insulin pump without any assistance or supervision.

Parental Permission/Consent

Parent's signature gives permission for child/youth personnel who have been trained in medication administration by the APHN or their designee to administer prescribed medicine and to contact emergency medical services if necessary. I understand that I am responsible for providing all of the medication and other necessary items for my child's/youth's care, to include sharps waste disposal and management. 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 Parent/Guardian	Parent/Guardian Signature	Date (YYYYMMDD)
Printed Name Youth, if applicable	Youth Signature	Date (YYYYMMDD)
Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)
Printed Name Program Director / FCC Provider	Program Director / FCC Director Signature	Date (YYYYMMDD)
Printed Name APHN/Health Consultant	APHN/Health Consultant Signature	Date (YYYYMMDD)

PILOT - CYS SERVICES DIABETES EMERGENCY MEDICAL ACTION PLAN

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Child/Youth's Name	Date of Birth	Date
Sponsor Name		
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Normal blood glucose range for child/youth: ______________ to ______________

Hypoglycemia - Mild to Moderate, blood glucose levels below 70 mg/dl and child is able to swallow (Low Blood Sugar) Symptoms

- ☐ Shakiness
- ☐ Pale or flushed face
- ☐ Sweaty
- ☐ Irritable/Confused
- ☐ Looks dazed
- ☐ Headache
- ☐ Weak
- ☐ Hungry
- ☐ Dizzy
- ☐ Other: ____

Treatment of Hypoglycemia (if child is unresponsive, or unable to swallow – initiate EMERGENCY RESPONSE)

1) If blood glucose is between ______________ and ______________ and child/youth is able to swallow give:
   - ☐ 3-4 glucose tablets
   - ☐ 15 gm glucose gel
   - ☐ A small cup of regular juice or soda (4 ounces)
   - ☐ Other: ______________________________

   Repeat blood glucose level in 15 minutes

2) If blood glucose is between ______________ and ______________ and child/youth is able to swallow, repeat food items per step 1.

   Repeat blood glucose level in 15 minutes

3) If blood glucose remains between ______________ and ______________, repeat food items per step 1 and contact parents for pickup for non-response of blood glucose levels.

If after steps 1-2 child/youth blood glucose is below _________ and/or for signs/symptoms of severely low blood glucose:

UNCONSCIOUS, UNRESPONSIVE, OR SEIZURES - CONDUCT EMERGENCY RESPONSE PROTOCOL!

EMERGENCY RESPONSE: SEVERELY LOW BLOOD GLUCOSE REQUIRES IMMEDIATE ACTION	**Notify Emergency Medical Services and notify parent/guardian.** ☐ **Administer Glucagon (as prescribed)**

Hyperglycemia - Mild to Moderate, blood glucose greater than 300 mg/dl (High Blood Sugar) Symptoms

- ☐ Frequent Urination
- ☐ Extreme Thirst
- ☐ Unable to Concentrate
- ☐ Nausea / Stomach ache
- ☐ Warm/dry flushed skin
- ☐ Combative behavior
- ☐ Heavy breathing
- ☐ Headache
- ☐ "Feels low"
- ☐ Other: ____

Treatment of Hyperglycemia

If blood glucose is between ______________ and ______________monitor for symptoms and check blood glucose per daily care plan.

If blood glucose is between ________________ and ________________:

- ☐ Give child/youth _______ cups of water per hour.
- ☐ Check ☐ Urine ☐ Blood ketones every ________ hour(s).
- ☐ Other: ____

Repeat blood glucose level in _______ minutes

If blood glucose is between ______________ and ______________ give an additional dose of insulin of _____________ units.

Repeat blood glucose level in _______ minutes

If blood glucose is between________________ and ______________ notify parents/guardian for pick-up.

For signs/symptoms of severely high blood glucose (hyperglycemia):

SHORTNESS OF BREATH, VOMITING, BLOOD KETONES OF __________, OTHER: _______________________

CONDUCT EMERGENCY RESPONSE PROTOCOL

EMERGENCY RESPONSE: SEVERELY HIGH BLOOD GLUCOSE REQUIRES IMMEDIATE ACTION	**For blood sugar above _______, Notify Emergency Medical Services and notify parent/guardian.** **Additional Instructions:**

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Follow Up

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

Field Trip Procedures

- 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 s/he **SHOULD** be allowed to carry and self-administer his/her medication. Youth has 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 is 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:____

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I agree with the plan outlined above.

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Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)
Printed Name Program Director / FCC Provider	Program Director / FCC Director Signature	Date (YYYYMMDD)
Printed Name APHN/Health Consultant	APHN/Health Consultant Signature	Date (YYYYMMDD)

Child Name ________________ **Pilot Blood Glucose and Ketone Monitoring Log**

Date	Time	BG Reading	Ketone Reading	Signs, Symptoms, Action Taken (Include blood/urine ketone readings if applicable)	Initials

Printed name and signature of persons above supervising/conducting blood glucose or ketone testing:

_____________/_______________ _____________/_______________ ______________/_______________

_____________/ _______________ ____________/ ________________ _____________/ _______________

Child Name ___________ Pilot Weekly Food and Carbohydrate Log - Week of: __________

	BREAKFAST (time):					
	Pre-Meal BG	What Child Ate	How Much	Carb Count	Insulin Administration*	Dosage Verification (unlicensed personnel)
Mon					Insulin Dose: Given By:	Insulin Dose:
Tue					Insulin Dose: Given By:	Insulin Dose:
Wed					Insulin Dose: Given By:	Insulin Dose:
Thu					Insulin Dose: Given By:	Insulin Dose:
Fri					Insulin Dose: Given By:	Insulin Dose:

	LUNCH (time):					
	Pre-Meal BG	What Child Ate	How Much	Carb Count	Insulin Administration*	Dosage Verification (unlicensed personnel)
Mon					Insulin Dose: Given By:	Insulin Dose:
Tue					Insulin Dose: Given By:	Insulin Dose:
Wed					Insulin Dose: Given By:	Insulin Dose:
Thu					Insulin Dose: Given By:	Insulin Dose:
Fri					Insulin Dose: Given By:	Insulin Dose:

Date	AFTERNOON SNACKS (time):					
	Pre-Snack BG	What Child Ate	How Much	Carb Count	Insulin Administration*	Dosage Verification (unlicensed personnel)
Mon					Insulin Dose: Given By:	Insulin Dose:
Tue					Insulin Dose: Given By:	Insulin Dose:
Wed					Insulin Dose: Given By:	Insulin Dose:
Thu					Insulin Dose: Given By:	Insulin Dose:
Fri					Insulin Dose: Given By:	Insulin Dose:

Date	ADDITIONAL SNACKS (time):					
	Pre-Snack BG	What Child Ate	How Much	Carb Count	Insulin Administration*	Dosage Verification (unlicensed personnel)
Mon					Insulin Dose: Given By:	Insulin Dose:
Tue					Insulin Dose: Given By:	Insulin Dose:
Wed					Insulin Dose: Given By:	Insulin Dose:
Thu					Insulin Dose: Given By:	Insulin Dose:
Fri					Insulin Dose: Given By:	Insulin Dose:

***Insulin dose determined by non-licensed CYS Services personnel must be conducted independently by two persons and dosage calculation verified. Initials of all persons who calculated dosage must be documented for each meal and snack. Calculation must be conducted by the person administering the insulin. Printed name and signature of persons administering Insulin above:**

______________ /________________ ______________ /________________ _______________ /_______________

______________ / ________________ ______________ / ________________ ______________ / ________________