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

PILOT - CYS SERVICES DIABETES DAILY MEDICAL ACTION PLAN

(Form to be completed by Health Care Provider)

Child/Youth's Name	Date of Birth	Date

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)