ARMY CHILD, YOUTH AND SCHOOL SERVICES
DIABETES DAILY MEDICAL ACTION PLAN

For use of this form, see AR 608-10; the proponent agency is DCS G-9.
(To be completed by a licensed Healthcare Provider)

Installation:
Program:
Case #:
Date Received from Patron:
Date to APHN:

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs; DoDI 6060.02, Child Development Programs; AR 608-10, Child Development Services.

PRINCIPAL PURPOSE: Information will be used to assist Army activities in their responsibilities in the overall execution of the Army's Child, Youth and School Services Programs

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 utilize Army Child, Youth and School Services Programs.

Child/Youth Name	Date of Birth	Date	Sponsor Name

Sponsor Phone Number	Health Care Provider	Health Care Provider Phone Number

In order to ensure the child/youth can be accommodated in 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 parents/guardian. This plan should be developed with the understanding that CYS Services personnel (non-medical personnel) responsible for caring for children in a group setting will perform the majority of the tasks ordered on this Diabetes Medical Action Plan.

Date of Diabetes Diagnosis:_____ □ Type1 □ Type 2 □ other: _____
DAY/MONTH/YEAR

Target blood glucose range for child/youth: _____ to _____

Daily Care Required During Child Care Hours

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

□ Other: _____

Supplies & Medication Storage (all supplies and medications supplied by parent/guardian)

□ Blood Glucose Meter & Test Strips □ Ketone Test Strips (& Meter if used) □ Lancets □ Glucagon □ Insulin Pen □ Insulin Vial & Syringe

□ Verification of serving size
□ Verification of amount of food consumed and calculation of carbohydrate count.
□ Documentation of Food Consumed on Food Log
□ Verification of carb data entry into insulin pump
□ Insulin dosage calculation or verification (insulin pump)
Other: _____

BLOOD GLUCOSE MONITORING

Check blood glucose: □ Before Meals □ Before Snacks □ _____ Hours After Meals/Snacks
□ Before Activity □ After Activity □ Prior to leaving care

Note: If hyperglycemia or hypoglycemia is suspected, a blood glucose check will be conducted.

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 fingertips will be used to check blood glucose.

□ **No -** Child/Youth has a Continuous Glucose Meter (CGM) - Brand/Model: _____
Alarms set for: : Low: _____ (mg/dl) High: _____ (mg/dl).
CGM results will be confirmed with a finger stick check before taking action based on CGM alarms.

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

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

□ **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 self-carry monitoring items (meter, lancets, and test strips) and can responsibly maintain and dispose of lancets

INSULIN THERAPY – CHILD/YOUTH OVERSIGHT BY STAFF

Route: □ Insulin Pump □ Syringe & Vial □ Insulin Pen

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

Preferred Injection Site: □ Stomach □ Upper Arm □ Thigh □ Buttocks □ Other: _____

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

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 – MEAL BASE DOSING (for symptom based dosing see Diabetes Emergency Medical Action Plan)

For children under the age of five, meal based insulin dosing will only be administered after meal completion when a more accurate count of carbs can be determined.

□ Child/Youth is over age 5 and understands the ramifications of pre-meal dosing. Insulin to be administered pre-meal.

Note: 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 Services Standardized Menu with Nutritional Data*

□ **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

□ DO NOT give insulin for snacks.

□ Other: _____

Child/Youth can determine own insulin dosages and self-administer insulin:

□ **No -** Parent/Guardian, Emergency Designee, or authorized personnel must determine dosage and administer insulin injections.

□ **Yes with assistance**, Parent/Guardian, Emergency Designee, or authorized personnel must determine dosage; child/youth can administer insulin with assistance.

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

INSULIN PUMP:

Brand/Model: _____ Type of Insulin: _____

□ For insulin dosage determination use Insulin Pump Wizard

□ For blood glucose greater than _____ mg/dl for _____hours call parents/guardian for pickup.

Child/Youth can self-manage their insulin pump:

□ **No –** Trained adult 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 glucose and meal information.

□ **Yes independently**, child/youth can independently manage their insulin pump with CYSS staff supervison.

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

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 by 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 APHN/Health Consultant	APHN/Health Consultant Signature	Date (YYYYMMDD)
Printed Name Program Director / FCC Provider	Program Director / FCC Director Signature	Date (YYYYMMDD)