ARMY CHILD, YOUTH AND SCHOOL SERVICES
DIABETES EMERGENCY 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 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 utilize Army Child, Youth and School Services Programs.

Child/Youth Name	Date of Birth	Date	Sponsor Name
James Doe	01/01/2012	04/17/2024	John Doe

Sponsor Phone Number	Health Care Provider	Health Care Provider Phone Number
717-854-0101	Dr. Suzan Lowry	717-245-3400

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.

Target blood glucose range for child/youth: 80 mg/dl to 160 mg/dl

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

- [X] Shakiness
- [ ] Pale or flushed face
- [ ] Sweaty
- [ ] Irritable/Confused
- [ ] Looks dazed
- [ ] Headache
- [ ] Weak
- [ ] Hungry
- [ ] Dizzy

Child Self Monitors

- [ ] Other: _____

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

1) If blood glucose is between 80 and 90 and child/youth is able to swallow give:
   - □ 3-4 glucose tablets **or** □ 15 gm glucose gel **or** **Child will Self Correct with Sugar Gummy**
   - □ A small cup of regular juice or soda (4 ounces) **or** □ Other: _____

   Repeat blood glucose level in 15 minutes

2) If blood glucose is between 80 and 90 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 80 and 90, 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 80 and/or for signs/symptoms of severely low blood glucose: UNCONSCIOUS, UNRESPONSIVE OR SEIZURES - CONDUCT EMERGENCY RESPONSE PROTOCOL!

EMERGENCY RESPONSE: SEVERLY LOW BLOOD GLUCOSE REQUIRES IMMEDIATE ACTION	**Notify Emergency Medical Services,** [X] **Administer Glucagon (as ordered)**

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 high"
- [X] Other: **Does Not Show Symptoms**

Treatment of Hyperglycemia

If blood glucose is between _____ and _____ and at least _____ hours since last insulin administration, monitor for symptoms and check blood glucose per daily care plan.

If blood glucose is between _____ and _____ and at least_____ hours since last insulin administration,:
- □ 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 or URINE KETONES OF _____; OTHER: _____

CONDUCT EMERGENCY RESPONSE PROTOCOL

EMERGENCY RESPONSE: SEVERLY **HIGH BLOOD GLUCOSE** REQUIRES IMMEDIATE ACTION	**For blood glucose above _____, Emergency Services and notify parent/ guardian. Additional Instructions:** **N/A-the child Self-Monitors, if child is Unconscious or Incoherent, CALL 911**

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

(Form to be completed by Health Care Provider)

Child/Youth Name	Date of Birth	Date
James Doe	01/01/2011	03/09/2024

DIABETES EMERGENCY MEDICAL ACTION PLAN - ADDITIONAL CONSIDERATIONS

POLICY STATEMENT

For all child/youth prescribed rescue medication, the medication is required to be at program site at all times while child/youth is in care. Child/youth without their prescribed rescue medication are not permitted to participate in program and may not remain on site. For youth who are approved to self-carry and administer their own medications, medication must be current and with the youth at all times. The options of storing "back up" rescue medications at the program is available.

FIELD TRIP PROCEDURES

This Medical Action Plan and prescribed Rescue Medication must accompany child/youth during any off-site activities or field trips.
Staff members on trip must be trained on rescue medication use and this health care plan.

INSTRUCTIONAL/SPORT EVENTS

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

MEDICAL ACTION PLAN 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 Medical Action Plan must be updated every 12 months from the date of the Health Care Providers signature below.

Self-Medication for School Age Child/Youth

☒ **YES.** Youth can self-medicate. I have instructed ___James Doe____ 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 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 are required to notify staff when carrying and administering medication.

OR

☐ **NO** It is my professional opinion that _____ SHOULD NOT carry or self-administer his/her medication.

Parental Permission/Consent

Parent's signature gives permission for CYS Services personnel who have been trained in medication administration by the Army Public Health Nurse or designee 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 Services Programs and may only self-medicate if approved by a licensed health care provider. My child/youth has been instructed on the proper way to use his/her medication. S/he understands not to share medications.

Licensed health care providers authorized to provide rescue medication approval are doctors of medicine (MD), osteopathic physicians (DO), certified registered nurse practitioners (NP), or certified physician's assistants (PA). If these guidelines are violated, CYS Services Programs privileges may be restricted or revoked.

Rescue medication must be on hand during all CYS Services Programs. CYS Services personnel must notify parent/guardian immediately if medication is given.

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 John Doe	Parent/Guardian Signature *John Doe*	Date *20240417* (YYYYMMDD)
Printed Name Youth, if applicable James Doe	Youth Signature *James Doe*	Date 20240417 (YYYYMMDD)
Contact Information/Stamp of Health Care Provider	Health Care Provider Signature *Dr. Suzan Lowry*	Date 20240415 (YYYYMMDD)
Printed Name APHN/Health Consultant Cindy Smith APHN	APHN/Health Consultant Signature *Cindy Smith, APHN*	Date 20240425 (YYYYMMDD)
Printed Name Program Director / FCC Provider	Program Director / FCC Director Signature	Date (YYYYMMDD)