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 Pr	ovider Phone			
AUTHORITY: PRINCIPAL PURPOSE: ROUTINE USES: DISCLOSURE:	PRIVACY ACT STATEMENT 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. 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. The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system. 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.						
child's health care p parent(s)/guardian(s a group setting may	be performing the tasks of	h the CYS Service veloped with the u ordered on this Dia	es child/youth c understanding t abetes Daily Me	enter's health hat child careg	consultant/Army P ivers (non-medica	ublic Health Nurse (A I personnel) responsi	PHN) and the ble for caring for children in
	s Diagnosis:						:
Normal blood g	ucose range for ch	ild/youth:		to			
DAILY CARE REQUIREMENTS (required during child care hours)							
Food Monitoring		Blood Gl	ucose Monitorir	g	Activity Mon	itoring	Insulin Therapy
□ Other:			•		•		
	ic Supplies and Emer				as and modicat	ione supplied by	naront/guardian)
-							
	eter & Test Strips    G - OVERSIGHT BY	Ketone Meter & Tr STAFF	est Strips	Lancets	Glucagon	Insulin Pen	□ Insulin Vial & Syringe
□ Meal/Snack Por				□ Ve	rification of accura	acy of counting of car	bohydrates
□ Verification of serving size				□ Verification of carb data entry into insulin pump			
□ Verification of amount of food consumed							
□ Documentation on Food Log			□Other:				
BLOOD GLUCOS							
Check blood glucose:			cks			_ Hours After Meals	/Snacks
Before Activity		After Activity			□ Prior to le		
	MONITORING – METER,		TEST STRIPS	CONTINUOU			
□ Yes - Brand/Moo	del of the blood glucose m	eter:					
Preferred testing	g site: 🗆 Fingertips	Forearm	🗆 Thigh	□ Ot	ner:		
Note: If severely low blood glucose (hypoglycemia) is suspected only use the fingertips to check blood glucose.							
Discrete No - Child/Youth	has a Continuous Glucos	e Meter (CGM) -	Brand/Model:				
Alarms set for: Lo	DW:	(mg/dl)		High:		(mg/dl)	
□ Take action base	ed on alarms and readings	6					
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 independ	□ 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 h	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 OVE	RSIGHT BY STAFF							
Given by:  □ Insulin Pump	□ Syringe & Vial	□ Insulin Pen						
	d/Youth	<ul> <li>Other:</li> </ul>						
Preferred Injection Site:	□ Upper Arm □ Thigh □ Buttoo							
Note: For rotation of injection sites, please er								
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 r								
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								
		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.								
<b>.</b>								
Child/Youth can determine own insulin dosage	Child/Xouth can determine own insulin desages:							
	esignee must determine dosage and administe	ar inculin injections						
	•	•						
<ul> <li>Yes with assistance, child/youth can determine dosage and administer insulin with supervision.</li> <li>Yes independently, child/youth can independently determine dosage and administer insulin without assistance or supervision.</li> </ul>								
	endently determine dosage and administer ins							
INSULIN PUMP:								
Brand/Model:								
For blood glucose greater than mg/dl forhours 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 put	mp:							
□ 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 Signa	ature Date (YYYYMMDD)						

APHN/Health Consultant Signature

Printed Name APHN/Health Consultant

Date (YYYYMMDD)