School Nurse
Telephone:(818)-360-2361 ext.389
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BRIAN BAUER
EXECUTIVE DIRECTOR

Granada Hill Charter High School
Diabetic Student Protocols

Student Name ______________________________ DOB____________ Type 1______ Type 2______

<u>Healthcare Provider's Opinion on Student Competency:</u>

Blood glucose testing [ ] indep [ ] supv Carbohydrate counting [ ] indep [ ] supv
Give insulin by injection [ ] indep [ ] supv Give insulin by insulin pen [ ] indep [ ] supv
Given insulin by pump [ ] indep [ ] supv

<u>Blood Glucose Monitoring:</u>

Target range of blood glucose: ☐ 70-100 ☐ 70-120 ☐ 70-150 ☐ 70-180 ☐ 100-200 ☐ Other

Check blood glucose with meter brought from home or additional meter left at school.
If independent, student may carry meter and check as necessary.
Student should be checked at the following times:
☐ before snacks ☐before exercise ☐before lunch
☐ mid-morning ☐ after exercise ☐for suspected hypo or hyper glycemia
☐no blood glucose testing at this time.

<u>Hypoglycemia:</u>

1. Treatment is given for low blood glucose less than _______mg/dL
2. Treat with 15 gram sugar source; i.e. 4 oz. of juice, 4 oz. regular soda, or 3-4 glucose tablets.
3. If initial blood glucose is less than 60mg/dL or if symptoms persist, re-check in 15 minutes and repeat step 2 if blood glucose still below 70mg/dL. *If student still hypoglycemic after 3 treatments call parents and physician.
4. If lunch or snack is more than one hour away give one of the following 15 minutes after juice:
 [ ] 15 gram CHO choice per parent or student
 [ ] 7-8 gram CHO choice per parent or student
5. Whenever possible the school nurse or designated trained adult should administer Glucagon if students becomes unconscious, is having a seizure, or is unable to swallow. This is a medical emergency. Glucagon can be given SQ or IM in the arm or thigh.
6. Glucagon dosage is 0.5mg=1/2 cc for students under 10 years of age and 1 mg = 1cc if ten years or older. 911 should be called if it is not possible to give Glucagon.

***Parent and medical provider should be informed after treatment of a severe low blood sugar event.**

<u>Hyperglycemia:</u> See Insulin Pump section ____

If blood glucose greater than 300 mg/dL, have student wash and dry hands thoroughly and re-check.
Check ketones for blood glucose greater than 300 mg/dL ___ Yes ___No. If ketones moderate to large notify parents and physician.
Insulin correction can be given before mid-am snack ___ Yes ____before lunch ____other.
Do not give correction more frequently than every 2 hours or if food was eaten within 2 hours.
Insulin for correction OR as determined by parent [ ] Humalog [ ] Novolog [ ] Apidra

	☐ **Low Dose Scale**	☐ **High Dose Scale**	☐ **Other**
BG 151-200	0.5 units	1.0 units	_________
BG 201-250	1.0 units	2.0 units	_________
BG 251-300	1.5 units	3.0 units	_________

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BG 301-350	2.0 units	4.0 units	_________
BG 351-400	2.5 units	5.0 units	_________
BG 401-450	3.0 units	6.0 units	_________
BG 451-500	3.5 units	7.0 units	_________
BG 501-550	4.0 units	8.0 units	_________
BG 551-Hi	4.5 units	9.0 units	_________

**If using Freestyle meter, Hi is 500 and over use correction dose for 501-550 mg/dL range*

Students on Fixed Regimen [ ] N/A [ ] Type of insulin: ______________________
[ ] Student is on a fixed meal plan with the following amount of carbohydrate (CHO) during school:
AM snack_______ Lunch ______ PM snack ______
Student can take insulin for additional carbohydrates: _____ units per _____ grams CHO

***Insulin therapy in case of disaster for students on fixed regimen: Check blood glucose every 3 hours and give correction according to the hyperglycemia protocol. Insulin to carbohydrate ratio should be followed when NPH insulin is no longer active.**

Students on Basal Bolus Insulin Regimen with Multiple Daily Injections (MDI) [ ] N/A
Type of basal insulin: ______________ dose: _____ time: _____ (Usually taken at home/given by parent)
Type of bolus insulin: _______________ Correction insulin dose: See Hyperglycemia Page 1
Insulin/carbohydrate ratio: _____ units per _____ grams CHO **(Need to take insulin EVERY time CHO's eaten)**

***Insulin therapy in case of disaster for students on MDI: Check blood glucose every 3 hours and give correction according to the hyperglycemia protocol in addition to insulin for carbohydrates.**

Students with Insulin Pumps [ ] N/A [ ] Type of insulin: ___________________
*Technical Support-call pump company number on back of pump. Clinical support-call your physician.

Basal rates can change often. These can be reviewed in the pump or written down by parents. Insulin/carbohydrate ratio: one unit of insulin will cover _____ grams CHO Correction/Sensitivity factor: one unit of insulin will decrease blood glucose _____ mg/dL
Insulin therapy in case of disaster for students on pump: Maintain basal rates as above with meal and correction boluses as needed.
If unable to administer insulin by the pump, check blood glucose every 4 hours and give correction according to the correction protocol above in addition to insulin for carbohydrates.

Exercise and Sports
The student may participate in sports: [ ] Yes [ ] No
Activity Restrictions: [ ] None [ ] Other: ____ Fast-acting carbohydrate should be readily available at all times for low blood glucose symptoms.
Student should not exercise if urine ketones are present or if blood glucose is less than 70 mg/dL.
Supplies to be kept at school: A blood glucose meter and strips along with back-up insulin (vial with syringes or pen) should be available for all students. Other items that may be brought in by parents include urine ketone strips, fast-acting source of sugar, carbohydrate containing snacks, Glucagon emergency kit and back-up insulin pump supplies.

Physician Signature: _________________ **STAMP:**__________ **Date:** _______________
This form is the only form that will be signed and replaces all school diabetes instructions and serves as authorization to have and receive medication at school.

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I give permission to the school nurse, trained diabetes personnel and other designated staff members to perform and carry out the diabetes care tasks outlined in this form. I also consent to the release of the information contained in this plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent Signature: ____ Date: ________________