GHC | GRANADA HILLS CHARTER

BRIAN BAUER
EXECUTIVE DIRECTOR

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# Diabetic Student Protocol

**Student Name** _____ **DOB**_____ **Type 1**_____ **Type 2**_____

**Healthcare Provider's Opinion on Student Competency:**

Blood glucose testing ◯ independent ◯ supervision
Give insulin by injection ◯ independent ◯ supervision
Given insulin by pump ◯ independent ◯ supervision
Carbohydrate counting pen ◯ independent ◯ supervision
Give insulin by insulin pen ◯ independent ◯ supervision

**Blood Glucose Monitoring: Desired Range: _____mg/dL**

◯ before meals ◯ before snacks ◯ before physical activity lasting >1hour ◯ As needed (i.e. ill, low)
◯ other _____

**Hypoglycemia:**

- Treatment is given for low blood glucose less than _____mg/dL
- Treat with _____g carbs: juice, glucose tabs, glucose gel, or another item provided by parent.
- Student must never be alone when hypoglycemia is suspected and should be treated on site.
- Recheck blood glucose in 15 mins.
- Repeat treatment if blood glucose below _____mg/dL

**Emergency care of severe hypoglycemia: Seizures, loss of consciousness, combative, unable to swallow**

◯ Glucagon IM _____mg into arm/thing. Call 911 if used
◯ Glucagon Nasal 3mg (one spray) into one nostril. Call 911 if used

**Hyperglycemia:**

- Do not give correction dose more frequently than every 2 hours.
- Check urine ketones if feeling ill & blood glucose >300 mg/dL
- Notify parent if BG >450 or if ketones med-large

**Exercise/Sport Guidelines:**

- Fast-acting carbs should be readily available at all times for hypoglycemia.
- No exercise if urine ketones are present or if blood glucose <70 mg/dL
- Student may participate in sports ◯ Y ◯ N
- Activity Restrictions ◯ None ◯ Other _____

**Insulin Orders**

Brand of bolus insulin ◯ Humalog ◯ Other _____
Insulin administration via ◯ Syringe ◯ Pen ◯ Pump ◯ Other: _____
Administer insulin bolus ◯ Before AM snack ◯ Before Lunch ◯ Other: _____

**Total Insulin bolus dose determined by**:

◯ Carbohydrate Coverage Dose: ____ unit(s) insulin per ____gms carbohydrates
◯ PLUS Insulin Correction Dose: ____units(s) for every ____mg/dL starting at _____mg/dL

**Correction Dosage Scale:**

BG 150-199 ____ units
BG 200-249 ____ units
BG 250-299 ____ units
BG 300-349 ____ units
BG 350-399 ____ units
BG 400-449 ____ units
BG 450-499 ____ units

**For calculated doses of insulin**

◯ Rounding for ½ units
0.1 – 0.3 round down
0.4 – 0.7 round to ½ unit
0.8 – 0.9 round up

◯ Rounding for whole units
0.1 – 0.4 round down
0.5 – 0.9 round up
0.1 – 0.3 round

◯ See attached form, contains doses above in table format

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BG 500-549 ____ units
BG 550+ or "HI" ____ units

**Other Needs: In case of disaster, check blood glucose every 4 hours & follow dosing instructions as directed above.**
◯ CONTINUOUS GLUCOSE MONITOR (CGM)- OK to use CGM to dose insulin. Verify hypoglycemia with a fingerstick
◯ INSULIN PUMP – Delivers continuous basal insulin that is variable and may change during the course of the day. Insulin settings can be reviewed in the pump or written down by parents. In addition, it delivers bolus insulin based on insulin correction factor and insulin to carb ratios, which may also change during the course of the day.
◯ OTHER ORDERS:_____
Technical Support: Call pump company number on back of pump. Clinical support: Call parent or clinic phone number.

**Parent Consent for Management of Diabetes at School**
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.

I will: Provide the necessary supplies and equipment
Notify the school nurse if there are changes in pupil health status or attending physician
Notify the school nurse immediately and provide a new consent for any changes in physician orders
Provide an updated diabetic protocol annually to the school nurse

**Parent Signature**: _____ **Date**: _____

**Physician Signature**: _____ **Date**: _____

**MEDICAL OFFICE STAMP (Required)**

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.

**HEALTH OFFICE USE (Do Not Write in This Box)**

Date Form Received _____ ◯ Supplies Received ◯ Medication Received Nurse_____ Parent _____

Date Med/Supplies Returned _____ Parent/Guardian Signature _____ Nurse _____