

Diabetic Student Protocol

Student Name _____ DOB _____ Type 1 _____ Type 2 _____

Healthcare Provider's Opinion on Student Competency:

Blood glucose testing ind sup Carbohydrate counting ind sup
 Give insulin by injection ind sup Give insulin by insulin pen ind sup
 Given insulin by pump ind sup

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 IN 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
 BG 500-549 _____ units
 BG 550+ or "HI" _____ units

For calculated doses of insulin

Rounding for ½ units Rounding for whole units
 0.1 – 0.3 round down 0.1 – 0.4 round down
 0.4 – 0.7 round to ½ unit 0.5 – 0.9 round up
 0.8 – 0.9 round up 0.1 – 0.3 round
 See attached form, contains doses above in table format

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.

<u>HEALTH OFFICE USE (Do Not Write in This Box)</u>			
Date Form Received _____	<input type="radio"/> Supplies Received	<input type="radio"/> Medication Received	Nurse _____ Parent _____
Date Med/Supplies Returned _____	Parent/Guardian Signature _____		Nurse _____