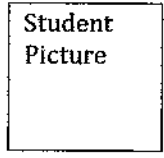
CONFIDENTIAL **District:**



Individualized Health Plan: Diabetes in School Setting

Date of Plan: ____ **Date of Orders:** ____

To be completed by School Nurse in consultation with Parent, School staff and per HealthCare Provider Orders
See Colorado Diabetes Standard of Care Guidelines for the School Setting

Student: ____ DOB: ____
School: ____ Grade: ____ Teacher: ____

Health Concern: ☐ Type 1 Diabetes ☐ Type 2 Diabetes Other: ____ Date of Diagnosis: ____
Mother/Guardian: ____ Preferred Tel #: ____
Father/Guardian: ____ Preferred Tel #: ____
School Nurse: ____ Work#: ____
Physician: ____ Work#: ____
Diabetes Educator: ____ Work#: ____
Hospital of Choice: ____ 504 on file? ☐ Yes ☐ No
Comments: ____

TARGET RANGE – Blood Glucose:	____mg/dl	**TO**	____**mg/dl**
Notify Parents if Blood Glucose values below:	____**mg/dl**	**or greater than:**	____**mg/dl**

Medications:

Insulin Dosing – see *Insulin Injection Administration or Pump Administration Addendum*
Insulin Delivery Device: ☐ Insulin Pen ☐ Insulin Pump ☐ Syringe & Vial Insulin Type: ____
☐ Parent/guardian elects to give insulin needed at school Notify parent/guardian for correction if Blood Glucose ≥ ____**mg/dl**
Glucagon Dose: ____**mg** **Intramuscular in** ☐ **Arm** ☐ Buttock ☐ Thigh - *See Severe Hypoglycemia Care

Required Blood Glucose Monitoring at School *(See Blood Glucose Treatment Plan)*

Where to check Blood Glucose: ☐ Health Room ☐ Classroom Other: ____
☐ Student can carry supplies and test where needed and when needed
☐ Continuous glucose monitoring: *Always Confirm glucose level with a fingerstick/meter prior to treatment*
Alarms set for: **Low:** ____**mg/dl** **High:** ____**mg/dl**

When to Check Blood Glucose:

☐ As needed for signs/symptoms of low/high blood glucose and/or does not feel well ☐ Behavior Concern
☐ Before School Program ☐ Before Snack ☐ Mid-morning ☐ After School Program/Extracurricular Activity
☐ Before Lunch ☐ After Lunch ☐ Recess ☐ Before PE ☐ After PE
☐ School Dismissal ☐ Before riding bus/walking home ☐ 2.5 hrs after correction Other: ____

Student's Schedule:

Location of Snacks: ____ Location Eaten: ____
Lunch: ____ PE: Recess: Snack: am pm

Class School Parties or Events with Food:

☐ In the event of Class Party – may eat the treat and insulin dosage per Provider Orders
☐ Student able to determine whether to eat the treat
☐ Replace with parent supplied treat ☐ May *NOT* eat the treat ☐ Contact Parent Prior to event for instructions

Classroom Emergency Preparedness:

☐ Snack/Water in classrooms (provided by parent)
Supplies to be kept: (indicate location)

Standardized Academic Testing Procedures: School Staff to notify Parents and School Nurse of upcoming standardized testing in order to create a plan for Blood Glucose monitoring and treatment.

Student's Self Care (ability level to be determined by School Nurse and Parent with input from Health Care Provider prn)

Totally Independent Management	☐ Yes	☐ No	☐ Agreement for Student's Independent Management Completed
Assist/supervise blood glucose testing by trained staff	☐ Yes	☐ No	
Blood glucose testing to be done by trained staff	☐ Yes	☐ No	
Administers Insulin Independently	☐ Yes	☐ No	
Insulin injections to be done by trained staff	☐ Yes	☐ No	
Self-Injects with verification of dose & supervision	☐ Yes	☐ No	
Monitors own snack and meals	☐ Yes	☐ No	
Trained staff to monitor food intake	☐ Yes	☐ No	
Independently Counts Carbs	☐ Yes	☐ No	
Trained staff to assist with carb counting	☐ Yes	☐ No	
Self-treats mild hypoglycemia	☐ Yes	☐ No	
Tests and interprets urine/blood ketones	☐ Yes	☐ No	

Other: ____

*See Pump Addendum for self-care pumps skills

Additional Information

Field Trip Information and Special Events:

1. Notify parent and school nurse in advance so proper training can be accomplished
2. Adult staff must be trained and responsible for student's needs on field trip
3. Extra snacks, BG meter, copy of health plan, glucagon, insulin & emergency supplies must accompany student on field trip
4. Adult(s) accompanying student on a field trip will be notified of student's health accommodations on a need to know basis

Exercise and Sports:

☐ Snack prior to PE ☐ Snack after PE ☐ Snack before Recess ☐ Snack after Recess # of Snack Carbs:

In general, there are no restrictions on activity except in these cases:

Student should not exercise if blood glucose is >300 and ketones is > small or until hypoglycemia/hyperglycemia is resolved

A source of fast-acting glucose & glucagon should be available in case of hypoglycemia

Special Instructions: ____

Staff Trained:	Monitor blood glucose & treat hypo/hyperglycemia	Give Insulin	Give Glucagon
1. ____	☐	☐	☐
2. ____	☐	☐	☐
3. ____	☐	☐	☐

Further Instructions: ____

See Addendum(s): ☐ Emergency Action Plan: Glucose Monitoring & Treatment ☐ Insulin Pump ☐ Insulin Injection & Medication Management ☐ Continuous Glucose Monitor ☐ Supplies ☐ Activity Plan

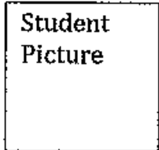
PARENT/GUARDIAN PERMISSION

I understand that:

- Medication orders are valid for this school year only & need to be renewed at the beginning of each school year.
- New Physician Orders are needed when there are any changes in the medication orders. (e.g. at quarterly clinic visits)
- Medication orders will become part of my child's permanent school health record.
- Medications must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for notifying the school nurse of any changes in Medication or care orders.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed medication administration, provider orders, and related student health information appropriate for my child's health and safety.
- I give my permission to the school nurse and designated staff to perform and carry out the diabetes tasks as outlined in this Individualized Health Plan (IHP).
- I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.
- Parent/Guardian & student are responsible for maintaining necessary supplies,snacks,blood glucose meter,medications & other equipment.

Parent Name:	Parent Signature:	Date:
School Nurse:	School Nurse Signature:	Date:

CONFIDENTIAL **District:**



Individualized Health Plan: Diabetes in School Setting

Date of Plan: _____ **Date of Orders:** _____

To be completed by School Nurse in consultation with Parent, School staff and per HealthCare Provider Orders
See Colorado Diabetes Standard of Care Guidelines for the School Setting

Student: _____ DOB: _____
School: _____ Grade: _____ Teacher: _____

Health Concern: ☐Type 1 Diabetes ☐Type 2 Diabetes Other: _____ Date of Diagnosis: _____
Mother/Guardian: _____ Preferred Tel #: _____
Father/Guardian: _____ Preferred Tel #: _____
School Nurse: _____ Work#: _____
Physician: _____ Work#: _____
Diabetes Educator: _____ Work#: _____
Hospital of Choice: _____ 504 on file? ☐ Yes ☐ No
Comments: _____

TARGET RANGE – Blood Glucose:	_____mg/dl	**TO**	_____**mg/dl**
Notify Parents if Blood Glucose values below:	_____**mg/dl**	**or greater than:**	_____**mg/dl**

Medications: Insulin Dosing – see *Insulin Injection Administration or Pump Administration Addendum*
Insulin Delivery Device: ☐ Insulin Pen ☐ Insulin Pump ☐ Syringe & Vial Insulin Type: _____
☐Parent/guardian elects to give insulin needed at school Notify parent/guardian for correction if Blood Glucose ≥ _____**mg/dl**
Glucagon Dose: _____**mg** **Intramuscular in** ☐**Arm** ☐ Buttock ☐ Thigh - *See Severe Hypoglycemia Care

Required Blood Glucose Monitoring at School *(See Blood Glucose Treatment Plan)*
Where to check Blood Glucose: ☐ Health Room ☐ Classroom Other: _____
☐ Student can carry supplies and test where needed and when needed
☐ Continuous glucose monitoring: *Always Confirm glucose level with a fingerstick/meter prior to treatment*
Alarms set for: **Low:** _____**mg/dl** **High:** _____**mg/dl**

When to Check Blood Glucose:
☐ As needed for signs/symptoms of low/high blood glucose and/or does not feel well ☐ Behavior Concern
☐ Before School Program ☐ Before Snack ☐ Mid-morning ☐ After School Program/Extracurricular Activity
☐ Before Lunch ☐ After Lunch ☐ Recess ☐ Before PE ☐ After PE
☐ School Dismissal ☐ Before riding bus/walking home ☐2.5 hrs after correction Other: _____

Student's Schedule: Location of Snacks: _____ Location Eaten: _____
Lunch: _____ PE: Recess: Snack: am pm

Class School Parties or Events with Food:
☐ In the event of Class Party – may eat the treat and insulin dosage per Provider Orders
☐ Student able to determine whether to eat the treat
☐ Replace with parent supplied treat ☐ May *NOT* eat the treat ☐Contact Parent Prior to event for instructions

Classroom Emergency Preparedness: ☐ Snack/Water in classrooms (provided by parent)
Supplies to be kept: (indicate location)

Standardized Academic Testing Procedures: School Staff to notify Parents and School Nurse of upcoming standardized testing in order to create a plan for Blood Glucose monitoring and treatment.

Student's Self Care (ability level to be determined by School Nurse and Parent with input from Health Care Provider prn)

Totally Independent Management	☐ Yes	☐ No	☐ Agreement for Student's Independent Management Completed
Assist/supervise blood glucose testing by trained staff	☐ Yes	☐ No	
Blood glucose testing to be done by trained staff	☐ Yes	☐ No	
Administers Insulin Independently	☐ Yes	☐ No	
Insulin injections to be done by trained staff	☐ Yes	☐ No	
Self-Injects with verification of dose & supervision	☐ Yes	☐ No	
Monitors own snack and meals	☐ Yes	☐ No	
Trained staff to monitor food intake	☐ Yes	☐ No	
Independently Counts Carbs	☐ Yes	☐ No	
Trained staff to assist with carb counting	☐ Yes	☐ No	
Self-treats mild hypoglycemia	☐ Yes	☐ No	
Tests and interprets urine/blood ketones	☐ Yes	☐ No	

Other: _____

*See Pump Addendum for self-care pumps skills

Additional Information

Field Trip Information and Special Events:

1. Notify parent and school nurse in advance so proper training can be accomplished
2. Adult staff must be trained and responsible for student's needs on field trip
3. Extra snacks, BG meter, copy of health plan, glucagon, insulin & emergency supplies must accompany student on field trip
4. Adult(s) accompanying student on a field trip will be notified of student's health accommodations on a need to know basis

Exercise and Sports:

☐ Snack prior to PE ☐ Snack after PE ☐ Snack before Recess ☐ Snack after Recess # of Snack Carbs:

In general, there are no restrictions on activity except in these cases:

Student should not exercise if blood glucose is >300 and ketones is > small or until hypoglycemia/hyperglycemia is resolved

A source of fast-acting glucose & glucagon should be available in case of hypoglycemia

Special Instructions: _____

Staff Trained:	Monitor blood glucose & treat hypo/hyperglycemia	Give Insulin	Give Glucagon
1. _____	☐	☐	☐
2. _____	☐	☐	☐
3. _____	☐	☐	☐

Further Instructions: _____

See Addendum(s): ☐ Emergency Action Plan: Glucose Monitoring & Treatment ☐ Insulin Pump
☐ Insulin Injection & Medication Management ☐ Continuous Glucose Monitor ☐ Supplies ☐ Activity Plan

PARENT/GUARDIAN PERMISSION

I understand that:

- Medication orders are valid for this school year only & need to be renewed at the beginning of each school year.
- New Physician Orders are needed when there are any changes in the medication orders. (e.g. at quarterly clinic visits)
- Medication orders will become part of my child's permanent school health record.
- Medications must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for notifying the school nurse of any changes in Medication or care orders.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed medication administration, provider orders, and related student health information appropriate for my child's health and safety.
- I give my permission to the school nurse and designated staff to perform and carry out the diabetes tasks as outlined in this Individualized Health Plan (IHP).
- I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.
- Parent/Guardian & student are responsible for maintaining necessary supplies,snacks,blood glucose meter,medications & other equipment.

Parent Name:	Parent Signature:	Date:
School Nurse:	School Nurse Signature:	Date:

Health Care Provider Orders for Student with Diabetes on Injections/Oral Medication

To be completed by the Health Care Provider and used in conjunction with the Standards of Care for Diabetes Management in the School Setting – Colorado 2014

Student:	DOB:	School:	Grade:
Physician/Provider:		Phone:	
Diabetes Educator:		Phone:	

TARGET RANGE – Blood Glucose: mg/dl TO mg/dl

☐ < 5y.o. 80-200mg/dl | ☐ 5 – 8 y.o 80-200mg/dl | ☐ 9-11y.o 70-180mg/dl | ☐ 12-18y.o. 70-150mg/dl | ☐ >18y.o. 70-130mg/dl

Notification to Parents: Low < *target range* and High ≥ 300 mg/dl or ***Other:*** less than ____ **mg/dl** and greater than: ____ **mg/dl**

☐ Continuous glucose monitoring: Always *Confirm glucose level with a fingerstick/meter prior to treatment*

Hypoglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here: ____

For *Severe Symptoms:* Call 911 & Administer **Glucagon Dose:** mg **Intramuscular in** ☐**Arm** ☐**Buttocks** ☐**Thigh**

Hyperglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here: ____

Ketone Testing: *per Standards of Care for Diabetes Management in the School Setting – Colorado* OR Other:

When to Check Blood Glucose: *For provision of student safety while limiting disruption to learning*

☐ **Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns**

☐ Before School Program ☐ Before Snack ☐ Mid-morning ☐ After School Program/Extracurricular Activity

☐ Before Lunch ☐ After Lunch ☐ Recess ☐ Before PE ☐ After PE

☐ School Dismissal ☐ Before riding bus/walking home ☐ 2.5 hrs after correction Other:

Blood Glucose Correction and Insulin Dosage Using (Rapid Acting/Short Acting) Insulin Type:

Injection site: ☐Abdomen ☐Arm ☐Buttock ☐Thigh | *Injections should be given subcutaneously & rotated*

Lunchtime Correction: Give ☐ Prior to lunch ☐ Immediately after lunch ☐ Split ½ before lunch & ½ after lunch ☐ Other :

☐**Sensitivity/Correction Factor:** ____ unit insulin for every ____ mg/dl above target BG range starting at ____ mg/dl

Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones

☐ Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin *per Guidelines for Insulin Management**

When hyperglycemia occurs other than at lunchtime:

☐ If it has been greater than **3 hours** since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders **if approved by the school nurse and parent is notified.**

☐ Contact Health Care Provider for One-time order

Carbohydrates and Insulin Dosage: ☐ **Breakfast** ☐**Snack** ☐**Lunch** ☐**Other:**

Insulin to Carbohydrate Ratio: ____ **unit(s)** for every ____ **grams** of carbohydrate to be eaten

☐ Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

☐ **Oral Medication:** ____ ____ mg Time: ____

☐ **NPH Insulin** Dose: ____ units SQ Time: ____

Student's Self Care: ☐No supervision ☐Full supervision, ☐Requires some supervision: ability level to be determined by school nurse and parent unless otherwise indicated here:

Additional Information:

Signatures: My signature below provides authorization for the written orders above and exchange of health information to assist the school nurse an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is for a maximum of one year.

Physician: ____________________ Date: ____________

Parent: ____________________ Date: ____________

School Nurse: ____________________ Date: ____________

Health Care Provider Orders for Student with Diabetes on Insulin Pump

To be completed by the Health Care Provider and used in conjunction with the Standards of Care for Diabetes Management in the School Setting – Colorado 2014

Student: DOB: School: Grade:
Physician/Provider: Phone:
Diabetes Educator: Phone:

TARGET RANGE – Blood Glucose: mg/dl TO mg/dl
☐ < 5y.o. 80-200mg/dl | ☐ 5 – 8 y.o 80-200mg/dl | ☐ 9-11y.o 70-180mg/dl | ☐ 12-18y.o. 70-150mg/dl | ☐ >18y.o. 70-130mg/dl

Notification to Parents: Low < *target range* and High ≥ 300 mg/dl or *Other:* less than____ mg/dl and greater than:____ mg/dl

☐ Continuous glucose monitoring: Always *Confirm glucose level with a fingerstick/meter prior to treatment*

Hypoglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado,* unless otherwise indicated here: ____

For *Severe Symptoms:* Call 911, Disconnect Pump, Administer **Glucagon Dose:** mg Intramuscular in ☐Arm ☐Buttocks ☐Thigh

Hyperglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado,* unless otherwise indicated here: ____

Ketone Testing: *per Standards of Care for Diabetes Management in the School Setting – Colorado* OR Other:

When to Check Blood Glucose: *For provision of student safety while limiting disruption to learning*

☐**Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns**

☐ Before School Program ☐ Before Snack ☐ Mid-morning ☐ After School Program/Extracurricular Activity
☐ Before Lunch ☐ After Lunch ☐ Recess ☐ Before PE ☐ After PE
☐ School Dismissal ☐ Before riding bus/walking home ☐2.5 hrs after correction Other:

Insulin Pump: *Follow Guidelines for Insulin Administration by School Staff, Diabetes Resource Nurses February 2013*

- Pump settings are established by the student's healthcare provider and should not be changed by the school staff. All setting changes to be made at home or by student providing self care as indicated on IHP.
- Internal safety features for the insulin pump should be active at all times while the student is at school - (Alarms set conservatively).

Insulin Pump Brand: ____ Type of Insulin in pump____

Correction Bolus:

- Provide Correction bolus per pump calculator. All BG levels should be entered into the pump for administration of pump-calculated corrections unless otherwise indicated on the provider orders.

☐**Sensitivity/Correction Factor:** _____ unit insulin for every _____mg/dl above target BG range starting at _____mg/dl
☐ If blood glucose is ***less than*** ___ ***mg/dl,*** wait to give meal bolus until after meal

When Hyperglycemia occurs other than at lunchtime:
☐ If it has been greater than **3 hours** since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders **if approved by the school nurse and parent is notified.**
☐ Contact Health Care Provider for One-time order

Carbohydrates and Insulin Dosage per pump: ☐ Breakfast ☐Snack ☐Lunch ☐Other:
Insulin to Carbohydrate Ratio: ______**unit(s)** for every _____ **grams** of carbohydrate to be eaten
Bolus for carbohydrates should occur immediately ☐ Prior to lunch/snack ☐After lunch/snack ☐ Split ½ before lunch & ½ after lunch ☐ Other: ____
☐ Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

Pump Malfunctions: Disconnect pump when malfunctioning
If pump calculator is operational then the insulin dosing should be calculated by using the pump bolus calculator and then insulin given by injection
If pump calculator is not operational: ☐ School Nurse or Parent to give insulin according to Insulin to Carbohydrate Ratio and/or Correction Factor
☐ Call Parent and Health Care Provider (for orders)

Student's Self Care: ☐No supervision ☐Full supervision, ☐Requires some supervision: ability level to be determined by school nurse and parent unless otherwise indicated here:

Additional Information:

Signatures: My signature below provides authorization for the written orders above and exchange of health information to assist the school nurse an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is for a maximum of one year.

Physician: ____________________ Date: ____________
Parent: ____________________ Date: ____________
School Nurse: ____________________ Date: ____________

Emergency Action Plan:
Glucose Monitoring Treatment

PHOTO:

STUDENT:		DOB:	GRADE/TEACHER:

☐TREATMENT PLAN: Low Blood Glucose (Hypoglycemia): Below ____ mg/dl

Causes: •Too much insulin •Too much exercise •High excitement/anxiety •Too few carbohydrates eaten for the amount of insulin given

If you see this:	Follow this: ACTION PLAN
Signs of Mild Low Blood Glucose **(STUDENT IS ALERT)** ▪ Headache ▪ Sweating, pale ▪ Shakiness, dizziness ▪ Tired, falling asleep in class ▪ Inability to concentrate ▪ Poor coordination ▪ Other: _____	1. Responsible person accompany student to health room or check blood glucose on site 2. Check blood glucose 3. If less than ______**mg/dl**, give one of the following sources of glucose: (~15gms for fast-acting sugar (student < 5 y.o. give 7.5gms) *(Checked are student's preferred source of glucose but if not available any of these may be used)* ☐ 2-4 glucose tablets ☐ 6-9 Sweettarts® candies ☐ 2-4 oz. Orange or other 100% juice ☐ 8 oz of milk ☐ 4-6 oz. sugar soda (not sugar-free) ☐ Other: _____ 4. After 10-15 minutes, **re-check** blood glucose 5. Repeat giving glucose & re-check if necessary until blood glucose is > ______mg/dl. *Do not give insulin for the carbs used to bring up glucose level* ☐ Follow with a 15gm complex carb snack (do not give insulin for these carbs) **OR** if lunch time – Send to lunch (give insulin per orders). *Notify parent/guardian & school nurse* Comments: _____
Signs of Moderate Low Blood Glucose **(Student has decreased alertness)** ▪ Severe confusion ▪ Disorientation ▪ May be combative	1. Check blood glucose 2. Keeping head elevated, give one of the following forms of glucose: • 1 tube Cake Mate® gel or instant glucose applied between cheek and gum 3. After 10-15 minutes, check blood glucose again 4. Re-treat if necessary, until blood glucose is > ______**mg/dl**, Follow with 15gm complex carb snack (do not give insulin for these carbs) 5. Suspend/disconnect pump. *Notify parent/guardian & school nurse* Comments: _____
Signs of Severe Low Blood Glucose ▪ Not able to or unwilling to swallow ▪ Unconsciousness ▪ Seizure **GIVE NOTHING BY MOUTH!**	1. **Call 911, activate Emergency response**, place student on their side, **CHECK BG** 2. If personnel are authorized give **Glucagon**, prescribed dose: ______**mg(s)** Intramuscular 3. Suspend/disconnect pump & send pump to hospital with parent/EMS 4. Remain with student until help arrives . *Notify parent/guardian and school nurse* Comments: _____

☐Treatment Plan: High Blood Glucose (Hyperglycemia) Blood Glucose above ____ mg/dl

Causes:: •Illness •Underestimated carbohydrates and bolus •Hormonal Changes •Increased stress/anxiety •Insulin pump not delivering insulin

Signs of High Blood Glucose (STUDENT IS ALERT) **Symptoms could include:** • Extreme Thirst • Headache • Abdominal Pain • Nausea • Increased Urination • Lethargic • Other: ***Note:*** • If on a pump, insulin may need to be given by injection – Contact school nurse & parent. • *Allow to carry water bottle & use rest room unrestricted.*	1. Provide blood glucose correction as indicated in Provider Orders or per pump. ***Recheck in 2 hours.*** 2. When hyperglycemia occurs other than at lunchtime – contact school nurse & parent to determine correction procedure per provider orders or one-time orders. 3. *Encourage to* drink water or DIET pop (caffeine free); *1 ounce water/year of age/per hour* 4. ***Notify parents and school nurse if BG ≥ 300mg or ______ as indicated on provider orders. Contact the school nurse for Exercise Restrictions and School Attendance per Standards.*** 5. ☐Check urine/blood ketones if BG is over **300mg/dl X2** or ______ *as indicated on provider orders.* & it has been > than 2 hours since last insulin dose. Recheck blood glucose in 2 hours following correction. Contact school nurse & parent with results. 6. ☐ Check urine ketones or ☐ blood ketones, if glucose **≥ 350mg/dl** or when ill, nausea, stomachache, lethargic, and/or vomiting. Contact school nurse & parent with results. 7. If BG **>300mg/dl** & urine ketones are **moderate to large or if blood ketones are greater than 1.0** mmol, **call parent & school nurse immediately! No exercise.** Recommend: Student to be released to parent/guardian for treatment/monitoring at home 8. **For PUMP users:** If BG ≥ 350 mg/dl & <u>ketones are positive</u>, insulin to be given by injection by School Nurse or delegated staff (can use pump calculator to determine bolus) and set change by parent/guardian or independent student. If ketones negative, give an insulin bolus via pump and retest in 1-2 hours. Then if the BG continues to be ≥ 350mg/dl, the correction bolus should be given by injection (can use pump calculator to determine bolus) and set change (to be changed by parent/guardian or independent student). Notify parents of BG results, ketone levels and actions. 9. If student's BG level is **≥350 mg/dl & symptomatic** (illness, nausea, vomiting) - notify school nurse & parent. Student must go home to be treated/monitored by adult. Comments:

Parent Signature:		Date:	
School Nurse Signature:		Date:	