

## DEMOGRAPHIC INFORMATION:

Student Last Name: \_\_\_\_\_ Student First Name: \_\_\_\_\_  
 Student Date of Birth: \_\_\_\_\_ Student Grade Level: \_\_\_\_\_  
 Student ID: \_\_\_\_\_ Diabetes Type: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

## CONTACT INFORMATION:

Parent/Guardian #1 First Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Parent/Guardian #1 Last Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
 Parent/Guardian #2 First Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Parent/Guardian #2 Last Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
 Primary Care Provider: \_\_\_\_\_  
 Primary Care Phone Number: \_\_\_\_\_  
 Provider treating the student's diabetes: \_\_\_\_\_  
 Provider treating the student's diabetes phone number: \_\_\_\_\_  
 Preferred Hospital: \_\_\_\_\_ Preferred Hospital Phone Number: \_\_\_\_\_  
 Preferred Hospital Address: \_\_\_\_\_

## SELF MANAGEMENT SKILLS:

**Please indicate the skill level of the student in regard to following diabetes management items:**

**Full support:** All care performed by school nurse and trained staff (as permitted by state law).

**Supervision:** Trained staff to assist & supervise. Guide & encourage independence.

**Self-Care:** Manages diabetes independently. Support is provided upon request and as needed.

**A) Blood Glucose Monitoring:**

Meter \_\_\_\_\_

CGM \_\_\_\_\_

Please check if CGM needs calibration

**B) Insulin Administration:**

Can calculate insulin doses \_\_\_\_\_

Syringe \_\_\_\_\_

Pump \_\_\_\_\_

Pen \_\_\_\_\_

**C) Carbohydrate Counting:**

\_\_\_\_\_

**D) Blood Glucose Management:**

Low Glucose \_\_\_\_\_

High Glucose \_\_\_\_\_

**E) Self Carry Diabetes Supply:**

Yes No

If yes, please specify. This may include their smart phone.

**F) Device Independence:**

\_\_\_\_\_

# STUDENT SYMPTOMS:

Please check all symptoms that the student experiences and if they are able to report them on their own.

## High Blood Glucose Symptoms:

Thirsty      Frequent Urination      Fatigue/Tired/Drowsy      Headache      Blurred Vision      Warm/Dry/Flushed Skin  
Abdominal Discomfort      Nausea/Vomiting      Fruity Breath      Unaware      Other: \_\_\_\_\_

## Low Blood Glucose Symptoms:

None      Hungry      Shaky      Pale      Sweaty      Tired/Sleepy      Tearful/Crying      Dizzy      Irritable  
Unable to concentrate      Confusion      Personality Changes      Other: \_\_\_\_\_

Has the student lost consciousness, experienced a seizure, or required Glucagon?: \_\_\_\_\_ If yes, date of last event: \_\_\_\_\_

Has the student been admitted for DKA after diagnosis?: \_\_\_\_\_ If yes, ate of last event: \_\_\_\_\_

# GLUCOSE MONITORING AT SCHOOL RELATED SITES:

**Monitor Glucose:** Before Meals      With physical complaints/illness (include ketone testing)      High or low Glucose Symptoms  
Before Exams      Before physical activity      After physical activity      Before leaving school  
Other: \_\_\_\_\_

**Continuous Glucose Monitoring (CGM):** Please specify the brand and model: \_\_\_\_\_

Specify viewing equipment:      Device Reader      Smart Phone      Smart Watch      Insulin Pump      iPod/iPad/Tablet

CGM is remotely monitored by parent/guardian.

May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

**CGM Alarms:** Low alarm \_\_\_\_\_ mg/dL if applicable      High alarm \_\_\_\_\_ mg/dL if applicable

## Perform finger stick if:

- Glucose reading is below \_\_\_\_\_ mg/dL or above \_\_\_\_\_ mg/dL
- If CGM is still reading below \_\_\_\_\_ mg/DL 15 minutes following low treatment
- If CGM sensor is dislodged or sensor reading is unavailable
- Sensor readings are inconsistent or in the presence of alerts/alarms
- Other: \_\_\_\_\_

**What steps would you like on site staff to take to manage high glucose levels?**

**Please enter any additional information here:**

**What steps would you like on site staff to take to manage low glucose levels?**

# STUDENT INSULIN ADMINISTRATION:

## Insulin Administered Via:

Syringe                      Insulin Pen -    Whole Units    Half Units  
 i-Port                        Smart Pen  
 Other: \_\_\_\_\_

Insulin Pump - please specify brand and model: \_\_\_\_\_

Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device

Insulin Pump is using DIY Looping Technology (child/parent manages device independently, nurse will assist with all other diabetes management)

Dosing to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 6A).

## Insulin Administration Guidelines:

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with students that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when student does not complete their meal.

### **Prior to Meal**

**After Meal** as soon as possible and within 30 minutes

**Snacking** - avoid snacking                      hours (default 2) before and after meals

### **Partial Dose Prior to Meal:** (preferred for unpredictable eating patterns using insulin pump therapy)

Calculate meal dose using                      grams of carbohydrate prior to the meal

Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)

May advance to Prior to Meal when student demonstrates consistent eating patterns.

### **For Injections, Calculate Insulin Dose To The Nearest:**

Half Unit (round down for < 0.25 or < 0.75 and round up for ≥ 0.25 or ≥ 0.75)

Whole Unit (round down for < 0.5 and round up for ≥ 0.5)

## Supplemental Insulin Orders:

Check for **KETONES** before administering insulin dose if blood glucose is greater than                      mg/dL or if the student complains of physical symptoms.

Parents/guardians are authorized to adjust insulin dose +/-                      units.

Insulin dose +/-                      units

Insulin dose +/-                      %

Insulin to Carb Ratio +/-                      grams/units

Insulin Factor +/-                      mg/dL/unit

Additional guidance on parent adjustments:

## Consulting Health Care Provider Information: :

Name of Health Care Provider or Clinic: \_\_\_\_\_

Name of Treating Physician: \_\_\_\_\_

Address of Health Care Provider or Clinic: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

# DOSING TABLE:

It is recommended to obtain the signature of your consulting health care provider for any updates made to this chart.

Health Care Provider Name: \_\_\_\_\_ Parent Name: \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

**Insulin:** (administered for food and/or correction)

**Rapid Acting Insulin:** Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) Other: \_\_\_\_\_

**Ultra Rapid Acting Insulin:** Fiasp (Aspart) Lyumjev (Lispro-aabc) Other: \_\_\_\_\_

**Other insulin:** Humulin R Novolin R

Meal & Times	Food Dose		Glucose Correction Dose		PE/Activity Day Dose
			Use Formula	See Sliding Scale 6B	
Select if dosing is required for meal	<b>Carbohydrate Ratio:</b> Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose		<b>Fixed Meal Dose</b>	<b>Formula:</b> (Pre-Meal Glucose Reading minus <b>Target Glucose</b> ) divided by <b>Correction Factor</b> = Correction Dose May give correction dose every _____ hours as needed (Default is 3 hours)	
<b>Breakfast</b>	Breakfast Carb Ratio = _____ g/unit	<b>Breakfast</b> units	<b>Target Glucose is:</b> _____ mg/dL & <b>Correction Factor is:</b> _____ mg/dL/unit	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units	
<b>AM Snack</b>	AM Snack Carb Ratio = _____ g/unit	<b>AM Snack</b> units	<b>Target Glucose is:</b> _____ mg/dL & <b>Correction Factor is:</b> _____ mg/dL/unit	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units	
	No Carb Dose	No Insulin if < _____ grams	<b>No Correction dose</b>		Subtract _____ units
<b>Lunch</b>	Lunch Carb Ratio = _____ g/unit	<b>Lunch</b> units	<b>Target Glucose is:</b> _____ mg/dL & <b>Correction Factor is:</b> _____ mg/dL/unit	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units	
<b>PM Snack</b>	PM Snack Carb Ratio = _____ g/unit	<b>PM Snack</b> units	<b>Target Glucose is:</b> _____ mg/dL & <b>Correction Factor is:</b> _____ mg/dL/unit	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units	
	No Carb Dose	No Insulin if < _____ grams	<b>No Correction dose</b>		Subtract _____ units
<b>Dinner</b>	Dinner Carb Ratio = _____ g/unit	<b>Dinner</b> units	<b>Target Glucose is:</b> _____ mg/dL & <b>Correction Factor is:</b> _____ mg/dL/unit	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units	
			<b>No Correction dose</b>		

## 6B. CORRECTION SLIDING SCALE

Meals Only	Meals and Snacks	Every	hours as needed
_____ to _____	_____ mg/dL = _____ units	_____ to _____	_____ mg/dL = _____ units
_____ to _____	_____ mg/dL = _____ units	_____ to _____	_____ mg/dL = _____ units
_____ to _____	_____ mg/dL = _____ units	_____ to _____	_____ mg/dL = _____ units

## 6C. LONG ACTING INSULIN

Time	Insulin	Units	Dose	Route
	Lantus, Basaglar, Toujeo (Glargine) Levemir (Detemir) Tresiba (Degludec) Other	units	Daily Dose Overnight Field Trip Dose Disaster/Emergency Dose	Subcutaneously

## 6D. OTHER MEDICATIONS

Time	Medication	Units	Dose	Route
	Metformin Other	units	Daily Dose Overnight Field Trip Dose Disaster/Emergency Dose	Route

**Thank you for completing this form.**

Once you have reviewed the completed form, please submit it to our Health and Wellness Coordinator and it will be uploaded to your student's health record.