

Standards of Care for Diabetes Management in the School Setting & Licensed Child Care Facilities – Colorado 2026



These guidelines are general standards of care for students with all forms of Diabetes, which are to be integrated and used with Colorado Provider Orders/Diabetes Medical Management Plans (DMMP), herein referred to as “Orders,” to create Individualized Health Plans (IHP). The student’s diabetes health care provider (HCP) may individualize and indicate exceptions to these standards in the individual Orders/DMMP.

www.coloradokidswithdiabetes.org

Legal protection:

- Federal and state laws prohibit discrimination against children with disabilities, including diabetes, in schools, child care programs, and community programs receiving federal funding or serving as public accommodations.
- These laws apply to religious schools, private schools, child care programs, camps, and community programs that meet these criteria.

Legal & Accommodation Plans

- IHP must match Orders and be developed in collaboration with parent/guardian(s).
- Students can self-carry all diabetes supplies (including phones for CGM/pump).
- Section 504 / IEP:
 - Accommodations and services should be detailed in the 504/IEP plan.
 - Applies to public & certain private/religious schools that receive government funding.
 - Prohibits discrimination in any program or activity (academic & extracurricular).
 - Requires evaluation by a knowledgeable 504 team (parent/guardian(s), SN/CCHC, teachers, admin).
 - Must align with provider Orders/DMMP; resolve discrepancies with provider.

Obligations:

- School/Child Care must provide care that allows students with disabilities (such as diabetes) to participate safely and fully.
- Includes all school-sponsored activities (extracurriculars, field trips, overnight, and out-of-state trips).

Role of School Nurse (SN)/Child Care Health Consultant (CCHC):

- Leads the care team to ensure timely, appropriate care per Orders/DMMP.
- Must understand their contracted responsibilities for all school-sponsored events.

Communication & Coordination

- SN/CCHC may share health info and communicate care with Health Care Provider (HCP) to create/update the IHP per HIPAA & FERPA guidelines.
- SN/CCHC may consult [Diabetes Resource Nurses of Colorado](http://DiabetesResourceNursesofColorado.org) for support.
- Parent/guardian(s) & SN/CCHC should create a communication plan for coordination of diabetes care at school (e.g., glucose readings, dosing changes, etc.) to include mode of communication (e.g., apps, email, texts) and noted in the student’s DMMP, IHP, 504, Individualized Education Program (IEP).
- Smart devices used with Continuous Glucose Monitoring (CGM) and insulin pumps are medically necessary and must remain accessible to the student and SN/CCHC and stay in proximity of the student.

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- Schools are strongly encouraged to provide internet access, as remote monitoring is becoming standard pediatric care. If internet access is unavailable, parent/guardian(s) may need to provide a data plan or Wi-Fi.
- Ensure substitute teachers are informed of the student's diagnosis and care plan.

Diabetes Health Care Provider Orders / DMMP

- Orders should be obtained annually or as needed.
- Acceptable forms: Barbara Davis Center, Children's Hospital Colorado, American Diabetes Association Orders/DMMP.
- Use additional district forms only if needed for clarification or for other medical conditions.
- DMMP can be tailored for each student within reasonable and safe accommodations.
- New diagnoses or other medical changes may need frequent insulin adjustments:
 - The clinic informs parent/guardian(s)
 - Parent/guardian(s) update school health staff
 - After stabilization, get updated provider Orders for new dose settings.

Screening for and Stages of Type 1 Diabetes (T1D):

- Refer to *Addendum A* for more information.
- Type 1 diabetes can be detected early with a simple blood test for T1D autoantibodies.
- Early screening and detection lower the risk of diabetic ketoacidosis (DKA) at diagnosis, helping to reduce risk for long-term complications.
- The school nurse should consider providing families with information about where T1D screening services are available: [ASKtheExperts.org](https://asktheexperts.org), <https://www.trialnet.org>

Nutrition Management in Schools

- Healthy nutrition supports health, growth, weight, and learning for all students.
- It is a misconception that students with diabetes should avoid foods with sugar and that sweets are not allowed.
- Providing menus/nutrition info in advance assists in meal planning and promotes desired glucose management.

SN/CCHC Role

- To help students develop a healthy relationship with food while understanding how it affects glucose levels.
- SN/CCHC and staff do not determine student/parent/guardian(s) food choices.

Carbohydrate Counting

- Focus on total carbs, which affect glucose directly.
- Know how to use labels, menus, apps, or parent/guardian(s) info to count carbs.
- For inconsistent eaters/newly diagnosed students, a post-meal dose or split-meal dose is recommended.
- SN/CCHC can calculate insulin dose if pump calculator fails:
 $(\text{Grams of Carbs}) \div (\text{Carb Ratio}) = \text{Insulin units}$ *Ex:* $\frac{45}{15} = 3.0$ units
 - Round down to the nearest whole or ½ unit (depending on pen/syringe) unless otherwise ordered.

Unique Events

- Coordinate food and insulin plans with parent/guardian(s) and include in IHP.

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- Share nutrition/unique events ahead of time with parent/guardian(s); have quick-acting carbs/hydration ready.

Disordered Eating Behaviors (DEB)

- More common in youth with diabetes using insulin; linked to poorer clinical outcomes and psychosocial well-being.
- SN/CCHC should notify parent/guardian(s)/providers if DEB is suspected and refer to mental health support.

Monitoring Glucose Levels

***Per the CDC, do not use blood glucose meters nor fingerstick devices for more than one student.**

Standard Target Ranges:

- Use target ranges specified in Orders.
- If none specified, use [standard range: 70-180 mg/dL](#)

Notification to Parent/guardian(s):

- Notify if glucose is below target range (low) or above 300 mg/dL (high), unless otherwise directed.
 - Always treat before notification. Follow the communication plan per the IHP.
- Refer to Hypoglycemia and Hyperglycemia sections for detailed notification guidelines.

Frequency of Monitoring:

- Consider a student's schedule and classroom activities to reduce disruption to learning.
- Typically, routine glucose checks are done 1-3 times during the school day unless otherwise ordered.

Hypoglycemia

- **See Table 1 for detailed guidance.**
- Treat students with low glucose or who are symptomatic immediately and in their current location if possible.
 - If hypoglycemia occurs during a meal, follow standard hypo protocol before continuing the meal.
 - If going to the health office, a responsible person must accompany the student per IHP/Section 504.
- Notify parent/guardian(s) *after* treatment (if requested) to avoid delay of treatment.
- Advise parent/guardian(s) to consult healthcare provider for insulin adjustments if hypoglycemia occurs frequently (e.g., 3+ days/week with 3+ lows) or when patterns are observed.
- Carbohydrate treatment is individualized. Follow *Table 1* for guidance if there are no Orders.
- Do not give insulin or enter carbs in pump for hypoglycemia treatment.
- Confirm the plan for insulin with post-hypoglycemia snacks with the parent/guardian(s); document it in the IHP.
- For mild hypoglycemia (>60 mg/dL, no symptoms), collaborate with parent/guardian(s) for individualized instructions.
 - Treat immediately per *Table 1* if parent/guardian(s) cannot be reached.

Hyperglycemia

- **Refer to Table 2 (injections), Table 3 (insulin pumps), and Table 4 (exercise/school with hyperglycemia).**
- Consider upcoming activities when giving insulin corrections.
- Advise parent/guardian(s) to contact HCP if patterns of hyperglycemia occur (e.g., ≥3 days/week at the same time).

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- Check ketones if symptoms appear (illness, nausea, vomiting, stomachache); contact parent/guardian(s) if unable to check.
- Ketones may indicate diabetic ketoacidosis (DKA); call 911 if symptoms worsen and parent/guardian(s) are unreachable.
- Assess the student's glucose and ketone levels if the student reports feeling unwell or exhibits moderate to severe symptoms. – **and do not allow them to exercise.**
- For pump malfunctions, UAP must notify SN/CCHC for instructions re: insulin by injection or new infusion set placement by parent/guardian(s) or independent student.
 - SN/CCHC can calculate correction dose if pump calculator fails:
$$(\text{Current glucose} - \text{Target}) \div \text{Correction/Sensitivity Factor} = \text{Insulin units}$$
$$Ex: \frac{250-150}{50} = 2 \text{ units}$$
 - Round down to the nearest whole or ½ unit (depending on pen/syringe) unless otherwise ordered.
 - Confirm doses with prior records or obtain a one-time HCP order if needed.
 - If Orders include a lower and upper glucose target, use the upper target for calculations.
 - Correction Factor and Sensitivity Factor are the same thing and used interchangeably. The proper terminology is to “correct” for glucose levels and to “cover” or “bolus” for carbohydrate intake.

Exercise in the School Setting

- Aerobic exercise may cause hypoglycemia for hours; some students may begin with hyperglycemia but risk low glucose later.
- Follow post-exercise insulin Orders for personalized guidance if available.
- Pre-exercise recommended glucose target is: 100–180 mg/dL unless otherwise ordered.
 - [See ADA Additional guidelines for Exercise and T1D.](#)
- Small carb snacks with no insulin bolus before/during exercise can help prevent hypoglycemia.
- Insulin pump activity/temp target modes can be used before activity to reduce insulin delivery without Orders.
 - Collaborate with parent/guardian(s) to develop a consistent plan for when to activate these modes prior to exercise.
 - Helps lower risk of hypoglycemia.
 - School staff should be trained on the use of exercise/activity modes.

Insulin Management

- Rapid/Ultra-rapid acting insulins are interchangeable and don't need new orders.
- Diluted insulin is okay to use in schools if prepared by provider/pharmacist and noted in Orders.
- Parent/guardian(s) should notify SN of insulin dose changes for updates to IHP.
- Rapid/Ultra-rapid-acting insulin can be given approximately 5-15 minutes before meals.
 - If hypoglycemia occurs before a meal, split the meal bolus or bolus for carbs immediately after the meal.
- Adjusting the timing of insulin based on the pre-meal glucose is not practical in the school setting (please refer to Hypo chart for instruction on timing with hypoglycemia).
- Refer to Orders for dosing for snacks.
- Insulin expires 28 days after first use; notify parent/guardian(s) for replacement.

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- Ask parent/guardian(s) if expired insulin should be returned or discarded.
- Follow district policies regarding the use of expired insulin in schools.
- Long-acting insulin may be given at school if Orders include dosing information.
- **Students using inhaled insulin require specific provider orders. Inhaled insulin replaces injections for mealtime dosing and high glucose corrections. See Addendum B for more information.**

Pump Management

- Use the pump's calculator for insulin boluses for carbs and glucose corrections.
 - Standard practice is to select “no” when prompted to reduce the bolus if below target. See IHP/DMMP for individualized instructions.
- Enter all carb grams (except hypoglycemia treatment) for carb bolus recommendations unless otherwise ordered.
- Some Automated Insulin Delivery (AID) systems may use carb estimations or meal announcements for meal bolus calculations. See Addendum A for more details.
- It is recommended to use glucose values no sooner than ~2 hours after the last bolus for correction to minimize interruptions to learning.
 - For students using inhaled insulin (Afrezza), post-meal correction doses are typically administered 60–90 minutes after eating, based on glucose levels. Refer to Orders for specific guidance.
- Parent/guardian(s) must ensure pump settings match current Orders.
- Avoid overriding pump bolus or entering fake carbs unless Orders specify; frequent overrides require HCP consult.
- For pump/infusion issues:
 - School staff should contact SN/CCHC and/or parent/guardian(s) for guidance.
 - If the pump site fails, give insulin by injection unless the site can be replaced immediately by parent/guardian(s)/student. Send the student home if backup insulin is unavailable within one hour.

Continuous Glucose Monitoring (CGM)

- **CGM Basics**
 - Sensors monitor glucose in interstitial fluid (not blood) continuously every 1-5 minutes.
 - Some devices may require a finger-stick calibration.
 - This should be done when glucose is stable and is usually done outside of school time.
 - The SN/UAP should calibrate only if prompted and when glucose is stable.
 - Parent/guardian(s)/independent students should change sensors if needed.
 - CGMs are interchangeable and do not require new orders.
- **Use in School/Child Care**
 - CGM provides real-time glucose data, improving safety and management.
 - *Continuous* remote monitoring by SN/Staff is not practical nor appropriate in the school setting.
 - The SN and 504 team should determine CGM plan per Orders.
 - CGM should be used for routine, periodic, or urgent glucose checks, with prompt response to all alarms.

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- Staff personal devices should not be used for remote monitoring. The school may choose to provide a tablet or smart device for the SN/CCHC/staff to use for scheduled glucose checks and receiving alarms.
 - Exceptions may be considered for short-term situations, such as overnight trips, etc.
- Use a blood glucose (BG) meter if CGM fails until the sensor is replaced by parent/guardian(s)/independent student.
- School/Child Care should have a policy in place regarding the use of CGM.
 - We recommend and concur with [ADA's Guidance for the use of CGM at school](#).
- **Alerts & Alarms**
 - Alarm settings should be set for “actionable,” not just “informational” glucose levels (e.g., < 80 or > 250 mg/dL) to avoid alarm fatigue and disruptions to learning.
 - UAPs should respond to actionable alarms, not constantly changing glucose levels.
 - Parent/guardian(s) set the alarms, which should be reasonable in the school/child care setting; urgent low (< 55 mg/dL) alarms cannot be disabled.
 - For predictive alarms, actions and/or treatment should be determined by parent/guardian(s) and SN and noted in IHP.
 - Trend arrows may guide mealtime insulin dosing per provider.
 - Refer to the manufacturer user guide for trend arrow recommendations specific to that product.
- **Staff Roles & Limitations**
 - Staff ensure safety but do not manage frequent glucose pattern adjustments.
 - Care is provided according to provider Orders.
 - Acetaminophen and/or high doses of Vitamin C may interfere with CGM accuracy; notify parent/guardian(s)/provider if needed for additional instruction.

Automated Insulin Delivery (AID) Devices

- AID technology connects insulin pumps with CGMs to deliver basal insulin, and in some cases, correction boluses, automatically.
- All require carb input/meal announcements for meal dosing. Dosing before meals improves glucose outcomes unless meal intake is uncertain (e.g., Student's meal intake may be unpredictable).
- Without CGM data, AIDs switch from automated to conventional “manual” mode for continued insulin delivery.

Clinical Research/Trials in Schools

- Students with any type or stage of diabetes may participate in research trials.
- Clinical trials may use non-FDA-approved treatments and require additional school absences.
 - Participation in these trials may require additional paperwork by the SN. See CDE guidelines for details.
- SN/staff should follow provider Orders and monitor for potential side effects while supporting the student.

Do-It-Yourself (DIY) Artificial Pancreas (AP) Systems

- Nurses must follow the Colorado Nurse Practice Act rules for insulin administration and delegation rules.
- SN/CCHC should support students with DIY systems according to these standards with a current Order.

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- Remote bolusing by parent/guardian(s) (bolus given offsite) is not recommended during school due to safety concerns.
 - If parent/guardian(s) chooses to “remote” bolus, SN/CCHC will still provide care per Emergency Action Plan only.

Multiple Interventions Per Day Outside of Orders and/or Overriding Insulin Pump Calculations

- Frequent parent/guardian(s) requests to override insulin dosing exceed reasonable accommodations.
- Multiple interventions disrupt education and raise hypoglycemia risks.
- School staff cannot provide this level of care due to scope of practice limits.

Self-Care Management

- Level of ability is determined by parent/guardian(s) and SN/CCHC with input as needed or if specified in Orders.
- Care is applied in the school setting as specified in the IHP.
- All students with diabetes, including independent students, require a care plan (e.g., an Emergency Care Plan) and may need assistance at times.
- Tier 3 training should be provided to staff when a self-managed student comes to school with Orders.

Bus Transportation to Home/Walking Home

- Glucose should be at or above 80 mg/dL and stable before the student is sent home.
- If glucose is high but ketones are negative/low and the student has no symptoms, the student may ride the bus or walk home.
- Follow DMMP/IHP student specific instructions.

Mental Health Considerations

- Depression, anxiety, ADHD, and disordered eating are more common in youth with diabetes.
- Students with diabetes and recent mental health treatment need a transition plan before returning to school.
- Providers, families, and school staff should collaborate on a safe diabetes management plan for school.
- Follow district and program mental health support procedures for all students.

Non-adherence to diabetes care:

- SN/CCHC, parent/guardian(s), and providers should:
 - Communicate concerns promptly.
 - Collaborate on problem-solving interventions.
 - Act as soon as possible to address issues.

Emergency Preparedness:

- Schools, child care programs and parent/guardian(s) should plan for extra diabetes supplies for potential emergencies.
- The Emergency plan should cover fires, tornadoes, lockdowns, evacuations, etc.
- Practice plan during school drills.
- Include details in student’s Section 504 plan.

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NOTE: SNs and CCHC's should determine their individual scope of practice regarding new diabetes treatment therapies and/or diabetes care practices according to State Laws. https://www.colorado.gov/pacific/dora/Nursing_laws.

Key Resources

- HIPAA & FERPA info: [HIPAA to School Nurse FAQ](#), [Parent/guardian\(s\) Guide to FERPA](#)
- Section 504 & Diabetes: [U.S. DOE Factsheet](#)
- [ADA and Public Accommodations Guide](#)
- [American Diabetes Association – Safe at School](#): Contact: 1-800-DIABETES or AskADA@diabetes.org
- [Diabetes Resource Nurses of Colorado](#)

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Addendum A – Quick Reference

Current & Emerging Therapies for Type 1 Diabetes (T1D) For School Nurses (SN) & Child Care Health Consultants (CCHC)

Key Points

- To stay current on devices & therapies to support students safely.
- Covers additional technology resources, screening and stages of T1D, teplizumab (Tziel) and upcoming technologies.

Resources

- **General Tech Info:** [PANTHERprogram.org](https://pantherprogram.org) – Printable insulin pump forms.
- **Minimed InPen Smart Pen:**
 - Overview → [YouTube](#)
 - Dose Calculator → [YouTube](#)
 - Cartridge/Dosing → [Minimed Training](#)
- **Minimed iPort Patch:**
 - [Minimed Product Page](#)

T1D Screening & Stages

- Screening: Detects islet autoantibodies before symptoms.
 - High-risk: relatives with T1D (~1 in 20)
 - 90% of those diagnosed with T1D have **no family history**.
 - Info: [ASKtheExperts.org](https://asktheexperts.org)
- **3 Stages:**

Stage	Definition	Support for Student
1	Multiple antibodies, normal glucose	Monitor for progression/symptoms
2	Antibodies + dysglycemia, no insulin needed	May use CGM intermittently, treat low symptoms
3	Clinical manifestation, needs insulin	Standard diabetes care plan

Teplizumab (Tziel) – Stage 2 and Stage 3

- FDA-approved to **delay Stage 3** and in use in early Stage 3.
- 14-day IV infusion (30 min/day).
- ↑ Infection risk during & four weeks post-treatment.
- **Precautions:** CDC infection guidelines + hand sanitizer in class.
 - [CDC School Infection Precautions](#)

Emerging Technologies

- **Continuous Glucose and Ketone Monitoring:**
 - Abbott is developing a new monitor that measures both glucose and ketone levels.
 - It is in clinical trials and not yet FDA approved; approval may come in the 2026–2027 school year.

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- The device provides glucose levels and trends, as well as ketone data.
 - How ketone data will be used clinically is still to be determined, but it is likely that ketone values may only display above a certain threshold (details still pending).
 - Continuous ketone monitoring (CKM) could help detect rising ketones early and help prevent DKA.
- **Simplified Meal Bolusing with Automated Insulin Delivery (AID):**
 - Fixed carbohydrate amounts can be used instead of exact carb counting for families who find carb counting difficult or burdensome as a more simplified approach.
 - Example: bolus 30g for small meal, 60g for regular meal, 90g for a large meal.
 - Fixed carb entries are typically based on a basic diet review.
 - Collaborate with parent/guardian(s) for individualized guidance.
 - Randomized trials comparing carb counting vs. fixed meal boluses with AID **show no difference or only small differences in time-in-range.** <https://pmc.ncbi.nlm.nih.gov/articles/PMC10148675/>
- **Automated Insulin Delivery Fully Closed Loop Technology**
 - AID is advancing from hybrid closed-loop systems requiring user-driven meal boluses to fully closed-loop (FCL) systems with automated meal dosing. Multiple FCL systems are undergoing FDA approval trials in children for the 2026–2027 school year.
 - Students participating in trials of FCL systems may be instructed to **not bolus for meals** as part of the FDA approval trial design. If a student is on an FCL system, please allow them to use the system as intended and do not require that they bolus for meals as the system will be doing it for them.
 - We anticipate that commercial FCL designs will come to market some time in 2027.
- **Inhaled Insulin: Afrezza: See Addendum B**

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Addendum B – Afrezza (Inhaled Insulin)

General information and Dosing Instructions

Key Points

- To stay current on devices & therapies to support students safely.
- Covers general information and dosing instructions for inhaled insulin (Afrezza) in the school setting.

Resources

- **Afrezza Instructions for School Nurse:** [Afrezza.com](https://www.afrezza.com)

General Information

- Afrezza is an inhaled version of rapid-acting insulin which uses an insulin cartridge and small inhaler device.
- It is used for mealtime dosing and high glucose corrections in place of rapid-acting insulin injections or pump boluses.
- The action of inhaled insulin differs from injected rapid-acting insulin. It begins working immediately and is cleared from the body within 60–90 minutes.
- The inhaler can be used for up to 15 days. After 15 days, inhaler must be discarded and replaced.
 - [Click here](#) for additional storage information for inhaled insulin cartridges (blister cards).

Dosing Instructions

- Inhaled insulin cartridges are available in 4-, 8-, and 12-unit doses. Students may use multiple cartridges to achieve the prescribed dose (e.g., 12 units + 4 units = 16 units).
- Inhaled insulin dosing is typically about twice the equivalent of rapid-acting insulin dose (e.g., 4 units of Afrezza is approximately equivalent to 2 units of injected Humalog or NovoLog).
- A dose for meals should be taken at the start of the meal, or within 20 min of starting to eat.
 - Unlike injected rapid-acting insulin, do not pre-bolus before meals.
- High glucose corrections may be given 60–90 minutes after a meal dose or previous correction dose.
 - This is standard practice and should be included in the IHP.
- See Orders for individualized timing of and glucose levels requiring corrections.

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Table 1: Hypoglycemia

Glucose < (less than) 70 mg/dL or lower than target indicated in Orders/DMMP

Predictive low alarms: actions and/or treatment should be determined by parent/guardian(s) and SN (document in IHP)

Scenario	Action
Student reports feeling “low,” symptoms are noted by staff, or CGM is alarming low. Even if CGM alarms again, wait full 15 minutes before re-treating unless student’s condition worsens	- Check blood glucose (BG) with glucometer or use CGM. If CGM reads < 80 mg/dL, or “LO” then check fingerstick - If no meter/sensor is available assume glucose is low and treat per symptoms
Mild Symptoms with or without glucose level below target range or Meter/CGM reads “LO”: Symptoms may include but are not limited to: Dizziness, irritability, moodiness, anxiety, hunger, shakiness, sweating (usually cold sweat), rapid heart beat	- Up to 5 years old: treat with ~ (approximately) 5-7 g fast-acting carbs* - Over 5 years old: treat with ~ 10-15 g fast-acting carbs* - Amount of carbs should be individualized and included on the IHP - Recheck glucose in ~15-20 min - If still below <i>Target Range</i>, repeat steps until within target range - Student may return to class when glucose >70mg/dL and they are asymptomatic - Consult IHP for follow-up snack instructions per parent/guardian(s) or follow <i>Snack/M Meal Protocol*</i> below
Moderate Hypoglycemic Symptoms with or without glucose level below target range: Symptoms may include but are not limited to: Confusion, headache, poor coordination	- Follow the same steps for “Mild Symptoms” above - Follow <i>Snack/M Meal Protocol*</i> (below) - If student is unable to drink or eat, this is severe hypoglycemia. Proceed to “Severe Symptoms” below
Severe Symptoms with or without glucose level below target range: Symptoms may include but are not limited to: severe drowsiness, fainting, loss of consciousness, seizures, unable or unwilling to eat or drink or take glucose gel	- Call 911 - Check BG with glucometer if available - Administer glucagon per manufacturer’s instructions, Orders/DMMP - Trained personnel should be available for administration of glucagon - Contact parent/guardian(s)

In all cases, notify parent/guardian(s) after the student has been treated per communication plan/DMMP/IHP.

- Fast-acting carbohydrates may include but are not limited to: juice, glucose tablets, Skittles, honey, regular soda, etc.
- Complex carb snacks can include crackers and cheese, meat and crackers, apple and cheese, etc.

- *Snack/M Meal Protocol:* Do not give insulin (do not enter in pump) for carbohydrates given to treat symptoms of and/or documented low glucose levels. Refer to IHP for insulin dosing for follow-up snacks.

Once the student’s glucose level is in range, they may eat, and insulin should be given after the meal based on carbohydrate intake, unless the DMMP or automated system requires a pre-meal dose. For pump users, enter carbs immediately after eating to calculate insulin, and do not use glucose values after a low to calculate the dose.

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**Table 2: Hyperglycemia for Students on Injections/Inhaled Insulin:
Glucose higher than target as indicated in Orders/DMMP**

Scenario	Action
Glucose 150-300 mg/dL: Before meal	Give correction per correction table in Orders/DMMP
Glucose 150-300 mg/dL: Outside of mealtime OR Glucose > 300 mg/dL once and non-symptomatic*	- Non-medical staff call SN for instruction - If < 3 hours since last insulin dose, wait and retest at ~3 hours - If <i>inhaled insulin</i>, give a correction 60-90 min after a previous dose using the dosing instructions in the orders. - If 3 hours or more since last insulin, give correction per Orders - If correction given between breakfast and lunch, give only carb dose at lunch - If correction given after lunch, inform parent/guardian(s) when correction was given
Glucose > 300 mg/dL for ~ 2 hours of duration OR *symptomatic as described above OR meter reads “HI” Use highest reading meter goes to (400-600 mg/dL)	- Non-medical staff call SN for instruction - Check Ketones - Ketones negative (less than 0.6 on meter) - Give correction per Orders if it has been at least 3 hours since last correction (60-90 since last correction dose if on inhaled insulin) - Ketones trace to small (0.6-0.9) - Give correction per Orders if it has been at least 3 hours since last correction - Encourage oral fluids - Recheck in ~2 hours - Ketones moderate to large (1.0 or greater) - Call parent/guardian(s) as student should be treated at home - If unable to reach parent/guardian(s), monitor and call HCP for assistance - If unable to reach parent/guardian(s) or HCP, call 911 - Encourage oral fluids - If Unable to check for ketones or child is symptomatic, follow above plan for “Ketones moderate to large” and/or <i>Table 4: Exercise and School Attendance</i>
- Glucose readings may come from CGM or fingerstick unless indicated otherwise. - If at any time a child (with or without a pump) has moderate to large ketones or blood ketones ≥ 1.0 mmol/L and the student has labored breathing, change in mental status and/or may be dehydrated – call 911. <i>Symptomatic:</i> Flu-like symptoms, nausea and/or vomiting, abdominal pain, severe drowsiness, rapid, shallow or deep breathing, confusion.	

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**Table 3: Hyperglycemia for Students on Pumps:
Glucose higher than target as indicated in Orders/DMMP**

Scenario	Action
Glucose 150-300 mg/dL: Before meal	• Use pump calculator for correction plus carb dosing
Glucose 150-300 mg/dL: Outside of mealtime	• Non-medical staff call SN for instruction if instructions not in IHP • If ~2 hours since last insulin dose, give correction per pump calculator per Orders
Glucose > 300 mg/dL: Once and Before meal Non-symptomatic*	• Use pump calculator for correction plus carb dosing • Recheck glucose in ~ 2 hours • If Glucose remains > 300 mg/dL at recheck, follow “Glucose > 300 for ~ 2 hours of duration” step below
Glucose > 300 mg/dL: Once and Outside of mealtime Non-symptomatic*	• If ~ 2 hours since last insulin dose, give correction bolus per pump calculator and continue to monitor for new symptoms* • Recheck glucose in ~ 2 hours • If glucose remains >300 mg/dL at recheck, follow steps below; infusion site must be changed by parent/guardian/independent student
Glucose > 300 mg/dL: For ~ 2 hours of duration or more OR symptomatic* as described below OR meter reads “HI” • Use highest reading meter goes to (400-600 mg/dL)	• Non-medical staff call SN/CCHC for instruction • Check Ketones* • Ketones negative (less than 0.6 mmol/L) to small (06.-1.0 mmol/L) ○ If ~ 2 hours since last insulin dose, give correction per pump calculator / continue to monitor for new or worsening symptoms* ○ Recheck glucose in ~ 2 hours ○ If > 250 mg/dL at recheck: ▪ Recheck ketones and follow these ketone level instructions ▪ Contact parent/guardian(s)/independent student for immediate infusion set change or give manual injection per Orders • If no Orders, call HCP for one-time Orders • Ketones moderate or greater (> 1.0 mmol/L) ○ Call parent/guardian(s); student should be treated at home ○ If unable to reach parent/guardian(s), monitor and call HCP for assistance. ○ If unable to reach parent/guardian(s) or HCP, call 911 ○ Encourage oral fluids • If unable to check for ketones follow <i>Table 4</i> for guidance
• Glucose readings may come from CGM or fingerstick unless indicated otherwise. • If at any time a student (with or without a pump) has moderate to large ketones or blood ketones ≥ 1.0 mmol/L and has labored breathing, change in mental status, and/or may be dehydrated – call 911. • <i>Symptomatic:</i> Flu-like symptoms, nausea and/or vomiting, abdominal pain, severe drowsiness, rapid, shallow or deep breathing, confusion.	

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Table 4: Hyperglycemia & Exercise and School Attendance:

***Definition of *Symptomatic* as used below: Flu-like symptoms, nausea and/or vomiting, abdominal pain, severe drowsiness, rapid, shallow or deep breathing, confusion.**

Key: < (less than) > (greater than) ≥ (equal to or greater than)

If Student's Symptoms & Glucose levels are...	and Ketone Level is ... then	Exercise	Stay in School
> 300 mg/dL: First time, no symptoms	Ketone testing not required <i>unless on pump</i>	Yes	Yes
> 300 mg/dL: 2 consecutive times (BG meter), or ~ 2 hours or more in duration (CGM), No symptoms	Negative to small	Yes	Yes, and continue to monitor for new symptoms
> 300 mg/dL <i>with symptoms</i> *	Negative or any ketones	No	No
> 300 mg/dL, with or without symptoms*	Urine: Moderate-Large or blood ketones ≥ 1.0 mmol/L	No	No
> 300 mg/dL: 2 consecutive times (BG meter), or ~ 2 hours or more in duration (CGM), No symptoms	<i>Unable to check ketones</i>	No	Yes, and continue to monitor for new symptoms
> 300 mg/dL, with symptoms*	<i>Unable to check ketones</i>	No	No

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