Cincinnati Children's Diabetes Center Insulin Dose Verification for a Student with Diabetes

Parenivguardian to complete infor		D ((D: "	
Student Name:		Date of Birth:	School Year:
School Name and Address:			Grade:
School Nurse/Personnel:			·
School Phone:	School	Fax:	
Insulin: ☐ Insulin lispro (Humalog® Insulin Administration: ☐ Syringe			_ , , ,
Insulin dose:			
Carbohydrate ratio for break Carbohydrate ratio for lunch: Correction target glucose: Correction factor: 1 unit for e Fixed Meal Insulin Dosing: E Other: Parent/Guardian Name (please print)	: 1 unit for grams o mg/dL every mg/dL above Breakfastunits Lui	f carbohydrates correction target nch units	
Parent/Guardian Signature	or Verbal Notific	ation by Parent/Gua	rdian for Dose Changes
Attention School Personnel: Fax for above.	orm to the CCHMC Diabe	tes Center for pro	ovider approval of doses
Provider's Signature	Date		
Cincinnati Children's Hospital Diabete Shivani Bhatt, APRN-CNP Ryan Brady, MD Sarah Corathers, MD Lisa Corker, MD Nancy Crimmins, MD Hailee Delsart, MD Lily Deng, MD Lawrence Dolan, MD Chineze Ebo, MD Deborah Elder, MD Janise Felblinger, APRN-CNP	☐ Bella Gustus, MD	NP	Noh, APRN-CNP Osborn, APRN-CNP otha Roberge, MD chaaf, APRN-CNP e Segev, MD Shah, MD Sheanon, MD onn Tatum, MD an Tellez, APRN-CNP a Thomas, MD ma Tilton, APRN-CNP

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