

HEALTHCARE PROVIDER ORDER FOR STUDENT WITH DIABETES

Student _____ DOB _____ School _____ Grade _____
Doctor _____ Phone _____ Diabetes _____ Phone _____
Educator _____

Monitor Blood Glucose Before lunch After lunch Before PE After PE Before snack Before getting on bus/going home As needed for signs/symptoms of low or high blood glucose

Blood glucose at which parent should be notified Low < _____ mg/dl and High > _____ mg/dl.

Target range for blood glucose > _____ mg/dl to < _____ mg/dl.

Hypoglycemia Student should not be sent to office unaccompanied if symptomatic or BS less than 70 mg/dl.

- Check blood glucose - if blood glucose meters not available, treat symptoms.
- Blood glucose below _____ mg/dl and/or symptomatic Treat with 10 to 15 gram carbohydrate snack.
- Mild symptoms: Treat with juice, glucose tabs, etc. until above _____ mg/dl, then snack or lunch.
- Moderate symptoms if unable to drink juice: Administer glucose gel. Retreat until above _____ mg/dl, then snack or lunch.
- Severe symptoms which may include seizures, unconscious, unable or unwilling to take gel or juice:
Administer Glucagon _____ mg(s) IM if trained staff available and call 911.

Hyperglycemia

- Check urine ketones if blood glucose is over 300 mg/dl or with symptoms of illness/vomiting. If ketones present, call parents, provide water and student should not exercise. Student may need insulin via injection.
- Use insulin orders (see below) when blood glucose is _____ mg/dl.
√ Recommend student be released from school when ketones are moderate/large or symptoms of illness in order to be treated and monitored more closely by parent/guardian.

Medication

Student is on oral diabetes medication(s) Dose: _____ Times to be given _____.

Student is on insulin . Type: _____ Dose: _____ Times to be given _____.

Blood Glucose Correction and Insulin Dosage using (Rapid Acting) Insulin: _____

Blood Glucose Range _____ mg/dl Administer _____ units
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If ketones present, call parents, provide water and student should not exercise.

Carbohydrate counting _____ unit(s) of insulin per _____ grams of carbohydrate with lunch.

- Parent/guardian authorized to increase or decrease correction within the following range: +/- 2 units of insulin.
 - Parent/guardian authorized to increase or decrease insulin to carbohydrate ratio within the following range: 1 unit per prescribed grams of carbohydrates +/- 5 grams of carbohydrates.
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Student's Self Care (ability level to be determined by school nurse and parent with input from healthcare provider)

Totally independent management. <input type="checkbox"/> Yes <input type="checkbox"/> No	Self injects with trained staff supervision. <input type="checkbox"/> Yes <input type="checkbox"/> No
(if independent, complete self-management agreement)	Injections to be done by trained staff. <input type="checkbox"/> Yes <input type="checkbox"/> No
Needs verification of blood glucose by staff. <input type="checkbox"/> Yes <input type="checkbox"/> No	Self treats mild hypoglycemia. <input type="checkbox"/> Yes <input type="checkbox"/> No
Assist/testing to be done by trained staff. <input type="checkbox"/> Yes <input type="checkbox"/> No	Monitors own snacks and meals. <input type="checkbox"/> Yes <input type="checkbox"/> No
Administers insulin independently. <input type="checkbox"/> Yes <input type="checkbox"/> No	Independently counts carbohydrates. <input type="checkbox"/> Yes <input type="checkbox"/> No
Self injects with verification of dose. <input type="checkbox"/> Yes <input type="checkbox"/> No	Monitors and interprets urine/blood ketones. <input type="checkbox"/> Yes <input type="checkbox"/> No

SIGNATURES

My signature below provides authorization for the above written orders and exchange of health information to assist the school nurse in developing 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.

Date of diagnosis _____

Physician _____

Date _____

Parent _____

Date _____

School Nurse _____

Date _____