HEALTHCARE PROVIDER ORDER FOR STUDENT WITH DIABETES ON PUMP

Student _____ DOB _____ School _____ Grade _____

Doctor _____ Phone _____ Diabetes Educator _____ Phone _____

Pump settings are established by the student's healthcare provider and should not be changed by school staff.

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

Notify parent when blood sugar <_____or >_____. Target range for blood sugar >_____mg/dl to <_____.

Hypoglycemia Student should not be sent to office unaccompanied if symptomatic or BS < _____ mg/dl.

- Check blood glucose - if blood glucose meters not available, treat symptoms.
- Blood glucose between _____ mg/dl and symptomatic: Treat with 10 to 15 gm carbohydrate (juice, glucose tabs, etc).
- Mild symptoms: Treat with 10 – 15 gms carbs. (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. Disconnect pump.

  Do not bolus for carbohydrates given to treat low blood glucose until blood glucose is > 70 mg/dl.

Hyperglycemia

☐ If BS >300 mg/dl with ketones or 2 consecutive unexplained BS >300 mg/dl (with or without ketones), i.e. malfunctioning pump. Student may require insulin via injection and/or new infusion site/set.

☐ First contact parent, if not available then call healthcare provider for further instructions. May need insulin via syringe.

Check ☐ Urine ☐ Blood ketones if blood glucose > _____ mg/dl

√ If ketones present, call parents, provide water and student should not exercise.

√ 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.

Insulin dosing for High Blood Glucose and/or Carbs

☐ Blood glucose correction when blood sugar >_____ and insulin dosage via syringe is only to be administered when confirmed by school nurse, parent or healthcare provider for treatment of hyperglycemia: Insulin – Type:_____

Blood Glucose Range _____ mg/dl Administer _____ units
Blood Glucose Range _____mg/dl Administer _____ units
Blood Glucose Range _____mg/dl Administer _____ units
Blood Glucose Range _____mg/dl Administer _____ units and check ketones
Blood Glucose Range _____mg/dl Administer _____ units and check ketones

Or Correction Factor: _____unit of insulin for every _____ mg/dl in blood glucose above _____.

Insulin to Carbohydrate ratio _____ units of insulin per _____ grams of carbohydrate.

Carbohydrate ratio for snack _____units per _____ gm of carbs _____am _____pm

Bolus for carbohydrates (or to be) eaten should occur immediately ☐ Before lunch ☐ After lunch ☐ ½ bolus before & ½ bolus after

☐ Parent/guardian authorized to increase or decrease sliding scale within the following range: +/- 2 units of insulin

☐ Parent/guardian authorized to increase of decrease insulin to carbohydrate ratio within the following range: 1 unit per prescribed grams of carbohydrates +/- 5 grams of carbohydrates.

Student's Self Care: (ability level)		Troubleshoots all alarms.	☐ Yes ☐ No
Independently monitors blood glucose.	☐ Yes ☐ No	Administers insulin independently.	☐ Yes ☐ No
Independently counts carbohydrates.	☐ Yes ☐ No	Self injects with verification of dosage.	☐ Yes ☐ No
Needs assistance with pump management.	☐ Yes ☐ No	Injection to be done by trained staff	☐ Yes ☐ No
Independently manages pump boluses.	☐ Yes ☐ No	Self treats mild hypoglycemia.	☐ Yes ☐ No
Inserts new infusion set.	☐ Yes ☐ No	Tests and interprets urine/blood ketones.	☐ Yes ☐ 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 _____