

Health Care Provider Order for Student with Diabetes on Injections

Student: _____ DOB: _____ School: _____ Grade: _____

Physician: _____ Phone: _____ Diabetes Educator: _____ Phone: _____

Monitor Blood Glucose As needed for signs/symptoms of low/high blood glucose and/or does not feel well
 Before School Program Before Snack Mid-Morning After School Program
 Before Lunch After lunch Recess Before PE After PE
 Extra-curricular activity Behavioral Concern 2.5 Hours after Correction
 School Dismissal Before Riding Bus/Walking home CGM alarms Other: _____

Target Ranges: < 5 y.o. 80-200 mg/dl 12-18 y.o. 70-150 mg/dl
 5-11 y.o. 70-180 mg/dl >18 y.o. 70-130 mg/dl OR _____ mg/dl to _____ mg/dl

Notification to Parents: Low < target range and **High** > 300 mg/dl or Other: _____ mg/dl to _____ mg/dl

Continuous glucose monitoring: Always *Confirm glucose level with a fingerstick/meter prior to treatment*

Hypoglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here: _____

For severe symptoms: Administer Glucagon < 16 years old = 0.5 cc and > 16 years = 1.0 cc IM OR _____ mg(s) IM, **Call 911**

Hyperglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here: _____

Ketone Testing *per Standards of Care for Diabetes Management in the School Setting – Colorado* OR Other: _____

Blood Glucose Correction and Insulin Dosage Using (Rapid Acting/Short Acting) Insulin Type: _____

Injection site: Abdomen Arm Buttock Other: _____ *Injections should be given subcutaneously & rotated*

To be given at: Prior to lunch Immediately after eating lunch Split ½ before lunch & ½ after lunch
 Other : _____

If Correction dose is needed other than at time indicated, School Nurse will contact Health Care Provider for One-time order

Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin *per Guidelines for Insulin Management**

Blood Glucose Range _____ mg/dl Administer _____ units

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

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Carbohydrates and Insulin Dosage:

Insulin to Carbohydrate Ratio: _____ unit(s) for every _____ grams of carbohydrate (or to be) eaten

Correction Factor: _____ unit of insulin for every _____ mg/dl in Blood glucose starting at _____.

Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

Medication: Follow *Guidelines for Insulin Administration by School Staff, Diabetes Resource Nurses February 2013*

Oral diabetes medication(s) Dose: _____ mg Times to be given: _____

NPH Insulin Dose: _____ units SQ Times to be given: _____

Student's Self Care: No supervision Full supervision, Requires some supervision: ability level to be determined by school nurse and parent unless otherwise indicated here: _____

Additional Information: _____

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.

Physician: _____

Date: _____

Parent: _____

Date: _____

School Nurse: _____

Date: _____