Maryland State Management of Diabetes at School/Order Form

This order is valid only for the Current School Year: ______(including summer session)

Student: ___________________________________ DOB: ____________________

School:_____________________________________ Grade:____________________

CONTACT INFORMATION

Parent/Guardian: ______________ Home Phone: _________ Work: _______ Cell/pager: __________

Parent/Guardian: ______________ Home Phone: _________ Work: _______ Cell/pager: __________

Other Emergency Contact:____

Insulin Orders (complete only if insulin is needed at school):

1. Insulin administration via:

 Syringe and vial Insulin pen Insulin pump Other _____________

 Insulin pump Type of pump: _____________ Basal rates:

2. Insulin Before Lunch/Meals: Name of Insulin: ___________

 Routine lunchtime dose: __________

 Per sliding scale as follows:

Meals

Blood Glucose	______	to	______	give____units
Blood Glucose	______	to	______	give____units
Blood Glucose	_____	to	______	give____units
Blood Glucose	______	to	______	give____units
Blood Glucose	______	to	______	give____units
Blood Glucose	______	to	______	give ____units
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Blood Glucose	______	to	______	give____units
Blood Glucose	_____	to	______	give____units
Blood Glucose	_____	to	_____	give____units
Blood Glucose	______	to	______	give____units

 Calculated insulin dose (add carbohydrate coverage and correction dose for total insulin dose): Carbohydrate Coverage:
Insulin to carbohydrate ratio Give _____ # unit(s) insulin per___gms carbohydrate. Correction:
Give_____ # unit(s) insulin per___ mg/dl of glucoseabove _____ mg/dl Subtract ____ # units for every ____ mg/dl of glucose below ____mg/dl

 Insulin may be given after lunch if _________________________

3. Other times insulin may be given:

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 Snack: Dose: ______ Calculated as above.

 Ketones: If ketones are ___________ Give/Add: _______unit(s)

If ketones are ___________ Give/Add: _______unit(s)

 Snack:

Blood Glucose Give:

________________units

________________units

_______________units

Health Care Provider Authorization for Management of Diabetes in School

My signature below provides authorization for the above written orders. This authorization is for a maximum of one school year. If changes are indicated, I will provide new written authorization, which may be faxed.

Health Care Provider Name: _____________ **Signature:** ________________ (original or stamped signature) ***Sign both sides.**

Address: ____________________________ **City:**______________ **Zip:** ___________

Phone: _________________ **Fax:** _____________ **Date:** ____________________

*Use for Preserver's Address Stamp

Parent Consent for Management of Diabetes at School

I (We) request designated school personnel to administer the medication and treatment orders as prescribed above. I agree

1. To provide the necessary supplies and equipment
2. To notify the school nurse if there is a change in the student's diabetes management or health care provider. I authorize the school nurse to communicate with the health care provider as necessary.

Parent/Guardian Signature ______________________ Date _____________ *sign both sides.

Student: ____________________

Blood Glucose Monitoring:

Target range for blood glucose monitoring at school:.

- Before snacks
- 2 hours or _______ hours after lunch
- Before meals
- 2 hours or _______ hours after a correction dose
- As needed for symptoms of hypo/hyperglycemia
- With signs and symptoms of illness
- Other times: __________________

Hypoglycemia - blood glucose less than ___________

 Self treatment for mild lows.

 Give ___ grams of fast-acting carbohydrate according to care plan. Recheck BG in 10-15 mins. Repeat treatment if BG less than __mg/dl

 Provide extra protein & carbohydrate snack after treating low if next meal/snack greater than __ minutes away

 Suspend pump for severe hypoglycemia for ___ mins.

If student is unconscious, having a seizure or unable to swallow, presume student is having a low blood sugar and:
Call 911, notify parent
** Glucagon injection (1 mg in 1 cc) ___ mg, subcutaneously or intramuscular (IM)**
** OK to use glucose gel inside cheek, even if unconscious, seizing.**
** Other:** ____________________

Hyperglycemia - blood glucose greater than ___

 Check urine ketones, follow care plan, administer insulin as per orders. For pumps, insulin may be given by syringe or pen if needed.

 Encourage sugar free fluids, at least ___ ounces per ___.

 If student complains of nausea, vomiting or abdominal pain; check urine ketones & check insulin administration orders.

 Other: ____

* Transport to local Emergency Room may be needed with vomiting and large ketones

Meal Plan

 AM Snack, time:________ PM snack time:________ Avoid snack is blood glucose greater than ____ mg/dl

 Lunch:

 Extra food allowed Parent's discretion Student's discretion

Exercise (check and/or complete all that apply)

Fast-acting carbohydrate source must be available before, during and after all exercise.

 With student With teacher

If most recent blood glucose is less than ___, exercise can occur when blood glucose is corrected and above ___.

 Eat ___ grams of carbohydrate Before Every 30 mins during After vigorous exercise

 Avoid exercise when blood glucose is greater than ____ or ketones are ____

Bus Transportation

 Blood glucose monitoring not required prior to boarding bus

 Check blood glucose 15 minutes prior to boarding bus

 Allow student to eat on bus if having symptoms of low blood glucose

 Provide care as follows: ______________________________________

Health Care Provider Assessment

Student can self-perform the following procedures (school nurse and parent must verify competency):

 Blood glucose monitoring Measuring insulin Injecting insulin Determining insulin dose

 Independently operating insulin pump

 Other: ____

Disaster Plan (if needed for lockdown, 24 hr shelter in place):

 Follow insulin orders as on Management Form

 Additional insulin orders as follows: ____________

 Administer long acting insulin as follows:.

 Other:____

Other instructions: ____________________

Health Care Providers Signature: ______________________________________ Phone: ___________________ Date: _____________________

Parent's Signature: ____ Phone:___________________ Date:______________________

Order reviewed by School Nurse (per local policy): _______________________________ Date:_______________________