HEALTHCARE PROVIDER ORDER FOR STUDENT WITH DIABETES

Student ___________________________ DOB ___________________________ School ___________________________ Grade ___________________________

Doctor ___________________________ Phone ___________________________ Parents ___________________________ Name ___________________________ Phone ___________________________

Test Blood Sugar: □ Before lunch □ After lunch □ Before Exercise □ After Exercise □ Before snack □ Before getting on bus
□ As needed for signs/symptoms of low or high blood sugar

► Blood sugar at which parent should be notified: Low < _________ mg/dl and High > _________ mg/dl.
► Target range for blood sugar > _________ mg/dl to < _________ mg/dl.
□ Type of Meter: ___________________________

Hypoglycemia: Student should be sent to office accompanied by an adult if symptomatic or BS < 80 mg/dl.

► Test blood sugar - if blood glucose meter not available, treat symptoms.
► Blood sugar < 80 mg/dl and symptomatic: Treat with 10 to 15 gram carbohydrate snack. Recheck BS in 15 minutes.
► Mild symptoms: Treat with juice, glucose tabs, etc. Recheck and retreat every 15 min. until BS > 80mg/dl, then snack/lunch.
► Moderate symptoms - if unable to drink juice: Administer glucose gel. Recheck and retreat every 15 min. until BS > 80 mg/dl, then snack/lunch.
► Severe symptoms (which may include seizures or unconsciousness) or unable/unwilling to take gel or juice: Administer Glucagon _______ mg(s) IM by trained staff and call 911. Contact parent/guardian.

Hyperglycemia:
► Check urine ketones if blood sugar is over 250 mg/dl or with symptoms of nausea/vomiting. If ketostix not available, treat with sliding scale insulin and give water. Recheck in 1 hour.
► If ketones present, call parents, provide water and STUDENT SHOULD NOT EXERCISE.
► It is recommended that student be released from school when having symptoms of nausea and vomiting in order to be treated and monitored more closely by parent/guardian.
► Use sliding scale insulin orders when blood glucose is _________ mg/dl. No exercise if BS > 300mg/dl without ketones.

Medication:
► Student takes □ oral diabetes medication(s) Dose: ___________________________ Times to be given: ___________________________
► Student takes □ insulin Type: __________ Dose: ___________________________ Times to be given: ___________________________
► Sliding Scale: Blood sugar correction and insulin dosage (may be used every 2 hours) Insulin: ___________________________
► □ Parent/guardian authorized to increase or decrease sliding scale within the following range: +/- 2 units of insulin.

Blood Sugar Range _________ mg/dl Administer _________ units
Blood Sugar Range _________ mg/dl Administer _________ units
Blood Sugar Range _________ mg/dl Administer _________ units
Blood Sugar Range _________ mg/dl Administer _________ units and check ketones
Blood Sugar Range _________ mg/dl Administer _________ units and check ketones
Blood Sugar Range _________ mg/dl Administer _________ units and check ketones

Carbohydrate counting:
► _______ unit(s) of insulin per _______ grams of carbohydrate with lunch.
► □ 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.

Student's Self Care: (ability level)
Totally independent management. □ Yes □ No Self injects with trained staff supervision. □ Yes □ No
Tests independently. □ Yes □ No Injections to be done by trained staff. □ Yes □ No
Needs verification of blood sugar by staff. □ Yes □ No Self treats mild hypoglycemia. □ Yes □ No
Assist/testing to be done by trained staff. □ Yes □ No Monitors own snacks and meals. □ Yes □ No
Administers insulin independently. □ Yes □ No Independently counts carbohydrates. □ Yes □ No
Self injects with verification of dose. □ Yes □ No Tests and interprets urine/blood ketones. □ Yes □ No

SIGNATURES
My signature below provides authorization for the above written orders and will 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 ___________________________

Please fax to School Health at 828-695-5104
HEALTHCARE PROVIDER ORDER FOR STUDENT WITH DIABETES ON PUMP

Student _____________________________ DOB _____________________________ School _____________________________ Grade _____________________________

Doctor _____________________________ Phone _____________________________ Parents Name _____________________________ Phone _____________________________

Test Blood Sugar: ☐ Before lunch ☐ After lunch ☐ Before Exercise ☐ After Exercise ☐ Before snack ☐ Before getting on bus
☐ As needed for signs/symptoms of low or high blood sugar
☐ Blood sugar at which parent should be notified: Low < _________ mg/dl and High > _________ mg/dl.
☐ Target range for blood sugar > _________ mg/dl to < _________ mg/dl.

☐ Type of Pump: _____________________________ ☐ Type of Meter: _____________________________

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

Hypoglycemia: Student should be sent to office accompanied by an adult if symptomatic or BS < 80 mg/dl.

☐ Test blood sugar - if blood glucose meter not available, treat symptoms.
☐ For BS < 80 mg/dl and symptomatic: Treat with 10 to 15 gram carbohydrate snack. Recheck BS in 15 minutes.
☐ Mild symptoms: Treat with juice, glucose tabs, etc. Recheck and retreat every 15 minutes until BS > 80mg/dl, then snack lunch.
☐ Moderate symptoms - if unable to drink juice: Administer glucose gel. Recheck and retreat every 15 minutes until BS > 80 mg/dl, then snack/lunch.
☐ Severe symptoms (which may include seizures or unconsciousness) or unable/unwilling to take gel or juice: Administer Glucagon _________ mg(s) IM by trained staff and call 911. Disconnect pump and contact parent/guardian.

☐ Do not bolus for carbohydrates given to treat low blood sugar until BS is > 80 mg/dl.

Hyperglycemia:

☐ BS >300 mg/dl with ketones or 2 consecutive unexplained BS >250 mg/dl (with or without ketones), may indicate a malfunctioning pump. Student may require insulin via injection and/or new infusion site/set.

☐ Contact parent, then healthcare provider if necessary, for bolus instructions. An order for insulin specific to the incident may be faxed from the healthcare provider. Verbal orders may be taken only by the RN and only in the event a fax is unavailable.

☐ Check ketones if BS > _________ mg/dl. If ketostix not available, bolus according to pump and give water. Recheck in 1 hour.

☐ If ketones, call parents, provide water and STUDENT SHOULD NOT EXERCISE. No exercise for BS > 300mg/dl without ketones.

☐ It is recommended that student be released from school when having symptoms of nausea and vomiting in order to be treated and monitored more closely by parent/guardian

Medication: Sliding Scale: Blood sugar correction and insulin dosage for pump malfunction (may be used every 2 hours)

Type of Insulin _____________________________

Blood Sugar Range _________ mg/dl Administer _________ units
Blood Sugar Range _________ mg/dl Administer _________ units
Blood Sugar Range _________ mg/dl Administer _________ units
Blood Sugar Range _________ mg/dl Administer _________ units
Blood Sugar Range _________ mg/dl Administer _________ units and check ketones
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Carbohydrate counting:

☐ _________ units of insulin per _________ grams of carbohydrate.

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

Student’s Self Care: (ability level)

<table>
<thead>
<tr>
<th>Task</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independently tests blood sugar.</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Independently counts carbohydrates.</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Needs assistance with pump management.</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Independently manages pump boluses.</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Inserts new infusion set.</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

| Troubleshoots all alarms. | ☐ Yes | ☐ No |
| Administers insulin independently. | ☐ Yes | ☐ No |
| Self injects with verification of dosage. | ☐ Yes | ☐ No |
| Injection to be done by trained staff | ☐ Yes | ☐ No |
| Self treats mild hypoglycemia. | ☐ Yes | ☐ No |
| Tests and interprets urine-blood ketones. | ☐ Yes | ☐ No |

SIGNATURES

My signature below provides authorization for the above written orders and will 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 _____________________________

Please fax to School Health at 828-695-5104