

****Emergency names and phone numbers are on computer health record****

Diabetes Orders

Student's Name _____ DOB _____

School _____

Physician _____ Effective Date _____

Physician Phone _____

Type of insulin: (circle one) Rapid or Short Acting: Apidra/Humalog/Novolog/Regular

Intermediate or Long-acting given at home: (circle one) NPH/Lantus/Levemir

Insulin to carbohydrate ratio (I:CR): _____ units/ _____ grams or Fixed insulin lunch dose _____

Parent may adjust I:CR by +/- 1 to 5 grams Yes/No (circle one)

Correction Factor (CF) (insulin sensitivity): CF: _____ units per _____ mg/dl over _____ mg/dl

(Correction Factor Formula: Student's BG minus Target BG ÷ correction factor = insulin dose)

Usual Insulin Dose Range _____ Target blood glucose range: 70-110 pre-meal. Other: _____

Insulin Pump: (if applicable)

Type: _____	Rate (units per hr)
Basal Rates:	
Time: _____	_____
12:00 am = _____	_____
_____	_____
_____	_____
_____	_____

Blood Glucose Monitoring (in classroom if possible) or Location _____

Before am snack _____

Before lunch _____

Before exercise _____

After exercise _____

Signs of low or high blood sugar _____

Other _____

Child is able to:

(Circle all that apply)

- Test own glucose _____
- Determine insulin dose Yes/No _____
- Draw up insulin Yes/No _____
- Administer insulin dose Yes/No _____
- Manage/troubleshoot pump Yes/No _____

Exercise and Sports

Student should not exercise if blood glucose is

BG is below _____ mg/dl or

above _____ mg/dl

Snack before exercise Yes/No _____

Snack after exercise Yes/No _____

Meals/ Snacks: _____

Breakfast _____

A.M. Snack _____

Lunch _____

P.M. Snack _____

Food in class, e.g. party _____

Supplies to be provided by parents: Blood Glucose Monitor and all monitoring supplies, Insulin and administration supplies, Glucagon emergency kit, snack foods, fast-acting glucose source, Ketone testing supplies, Insulin pump supplies if appropriate.

High blood glucose Management/Preventing Diabetic Ketoacidosis

If BG is above 250 mg/dl, wash hands and recheck. If still above 250:

→If less than 2 hrs since last dose of Apidra, Humalog or Novolog, *recheck at 2 hrs after the last dose and continue as below.

→If 2 hrs or more since the last dose of Apidra, Humalog, or Novolog* give a correction dose using the correction factor formula.

→Check urine for ketones. If positive, drink 6-8 oz liquid with no calories :every 30 minutes (e.g. water, diet soda)

→ If moderate or large ketones at any time, call parent.

→Check BG and ketones every 2 hrs and give correction dose until BG reaches target range and ketones clear.

→If BG and ketones are not decreasing after 4 hrs, call parent.

Additional Instructions for Insulin Pump Users:

→If ketones are negative, check pump and site. If okay, give correction) bolus by pump_

→If ketones are positive, give correction bolus by syringe (not by pump) and have student change infusion set/site if able or call parent.

→If initial correction bolus was given by pump, recheck BO in 1 hr. If BG has not decreased, give correction bolus by syringe and have student change infusion set/site if supplies are available or call parent.

→Check BG and ketones every 2 hrs and give correction dose until BG reaches target range and ketones clear, by syringe until site is changed.

If taking Regular, NPH or NPH mix insulin, call parent for direction.

Low blood glucose (hypoglycemia)

Some symptoms of low BO:

→Sweating..... →Hunger

→Headache..... →Dizziness

→Drowsiness..... →Confusion

→Trembling..... →Palpitations

→Blurred vision →Speech Impairment

Hypoglycemia protocol: the rule of 15

If blood glucose is less than 70 mg/dl or symptomatic (70 to 100 mg/dl)

→Eat/drink 15 grams of carbohydrate

→Check BG again in 15 minutes; if not above 70 mg/dl repeat treatment

→Check BG again in 15 minutes; if not above 70mg/dl repeat treatment and contact parent.

These items have 15 grams of carbohydrate:

→ 3 Glucose tablets..... →4 oz of juice or soda (not diet)

→6-7 hard candies such as lifesavers

→1 tablespoon of table sugar or honey

Rx:

Glucagon: If child becomes unconscious, unable to cooperate, or has a seizure, give glucagon 0.5/1.0 mg subcutaneously. (Please circle dose) Call 911 and parents. Do not force eating or drinking. Turn on side.

I hereby certify that the above information is complete and I have provided the school with all information that they will need to reasonably care for and monitor my child's health related to his/her diabetes. I give permission for the school to talk to my doctor, nurse practitioner, and/or physician's assistant and/or nurse.

Above I hereby certify that my child can monitor and manage his/her care without supervision from school personnel except in emergencies

Signature and dates: Parents _____ Student _____ Date _____

Physician _____ Date _____ School Representative and Title _____

Diabetic Care Plan

Name _____ DOB _____ Date _____

To be completed by parent/guardian and the health care team. This document should be reviewed with necessary school staff and kept with the child's health records.

Emergency Information

Parent/Guardian _____	Parent/Guardian _____
Home phone _____	Home phone _____
Work phone _____	Work phone _____
Cell/pager _____	Cell/pager _____

Emergency Contacts

Name _____	Name _____
Relationship _____	Relationship _____
Home phone _____	Home phone _____
Work phone _____	Work phone _____
Cell phone _____	Cell Phone _____

Notify parent/guardian in the following situations _____

Medical Alert yes _____ no _____ (please check)

Transportation Bus _____ Walk _____ Car _____ Bike _____ Other _____ (please check)

Hypoglycemia (low blood sugar)-please check the symptoms that apply to your child

- _____ irritability
- _____ hunger
- _____ shakiness
- _____ sleepiness
- _____ sweating
- _____ other symptoms (please describe) _____

At what time of day is the student most likely to have hypoglycemia?

Hyperglycemia (high blood sugar) please check the symptoms that apply to your child

- _____ headache
- _____ hyperactivity
- _____ visual changes
- _____ thirst
- _____ changes in usual behavior
- _____ frequent urination
- _____ other symptoms (please describe) _____

Please add anything that you would like school personnel to know about your student's diabetic/health condition

Parent/guardians must notify school nurse of changes in diabetic routine and/or medications and care plan will be updated to reflect changes.

Signature of parent/guardian _____ Date _____
Received by school nurse _____ Date _____
Updates _____