

HEALTHCARE PROVIDER ORDER & CARE PLAN FOR STUDENT WITH DIABETES (1 of 2)
 TO BE FILLED OUT BY PARENT/GUARDIAN:

Student: _____ DOB: _____ School: _____ Grade: _____
 Type _____ Diabetes/Year of Diagnosis: _____ This plan is only valid for the current school year: _____ -- _____

IF STUDENT IS SENT TO THE HEALTH ROOM THEY MUST BE ACCOMPANIED BY AN ESCORT.

HYPOGLYCEMIA: blood sugar less than 80mg/dl

Signs and symptoms of hypoglycemia:

- | | | | |
|-------------|--------------------|--------------------|-------------------------|
| • Dizziness | • Hunger | • Headache | • Loss of consciousness |
| • Shaking | • Blurry vision | • Behavior changes | • Seizure |
| • Anxiety | • Weakness/fatigue | • Pallor | |

1. Check blood sugar. If meter is not available and child has any of the above symptoms, proceed to step 2.
2. If blood sugar less than 80 mg/dl: Treat with 15 grams of fast acting carbohydrate (4 oz juice, 6 oz regular soda, 3-4 glucose tablets, 3-4 pieces of hard candy, 3 tsp of sugar, _____).

If unable to swallow safely, administer 1 tube of glucose gel to inside of cheek.

3. Recheck and retreat every 15 minutes until blood sugar greater than 80 mg/dl.
4. When blood sugar is above 80 mg/dl give a complex carbohydrate (crackers with cheese, granola bar, trail mix etc.), if it is going to be more than an hour until the next meal or snack.
5. If unable/unwilling to take fast acting carbohydrate, having seizures, or is unconscious: Administer Glucagon by trained staff, call 911, and contact parent/guardian.

If student has an insulin pump, suspend or remove pump.

HYPERGLYCEMIA: blood sugar greater than 300mg/dl

Signs and symptoms of hyperglycemia

- | | | | |
|----------------------|-----------|-----------------|-------------------|
| • Increased thirst | • Hunger | • Irritability | • Nausea/Vomiting |
| • Frequent urination | • Fatigue | • Double vision | • Abdominal pain |

1. Check blood sugar.
2. If blood sugar is over 300 mg/dl and greater than 2 hrs since last insulin dose, give insulin per sliding scale or bolus via pump.
3. **Check ketones.** If ketones are present, call parents. **STUDENT SHOULD NOT EXERCISE.**
4. Give 8-16 oz. of water per hr.
5. Recheck blood sugar in 2 hrs and treat with sliding scale insulin, as needed. * *See below for pump.*
6. When having symptoms of nausea and vomiting student will be released from school to parent/guardian.

*** When student has insulin pump:**

Blood sugar greater than 300 mg/dl with ketones or 2 consecutive unexplained blood sugars greater than 300 mg/dl (with or without ketones), may indicate a malfunction in the pump. Student may require insulin via injection and/or new infusion site. **PARENTS MUST BE NOTIFIED.**

SIGNATURES

My signature below provides authorization for the above written orders. 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.

I authorize the Diabetes Care Team to notify me/leave message via:

Voice mail Text E-mail: _____ Cell Phone _____
 Parent _____ Date _____ Alternate Phone _____

School Health Nurse Review: _____ Date: _____

HEALTHCARE PROVIDER ORDER & CARE PLAN FOR STUDENT WITH DIABETES (2 of 2)
 FOR LICENSED HEALTHCARE PROFESSIONAL USE ONLY:

Student: _____ DOB: _____ School: _____ Grade: _____
 Type _____ Diabetes/Year of Diagnosis: _____ This plan is only valid for the current school year: _____ -- _____

Trained School Diabetes Care Providers: _____, _____

Test Blood Sugar: Before lunch 2 hours after lunch Before exercise After exercise Before snack
 Before getting on bus As needed for signs/symptoms of low or high blood sugar

INSULIN ADMINISTRATION	GLUCAGON ADMINISTRATION
Route: <input type="checkbox"/> Pen <input type="checkbox"/> Injection <input type="checkbox"/> Pump – Type: _____ <input type="checkbox"/> If pump failure, use sliding scale	<input type="checkbox"/> .5 mg (less than 10 years) <input type="checkbox"/> 1.0 mg (more than 10 years)

Insulin type: Lantus: _____ units daily at _____

Insulin type: For Sliding Scale insulin dosage and blood sugar correction. ONLY to be used every 2 hours.
 Humalog Novolog Apidra

Parent/guardian authorized to increase/decrease sliding scale within the following range: +/- 2 units of insulin.
 If blood sugar greater than 300 mg/dl, check ketones.

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
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INSULIN/CARBOHYDRATE RATIO

- Breakfast: 1 unit of insulin per _____ grams of carbohydrate
- Mid Morning Snack: 1 unit of insulin per _____ grams of carbohydrate
- Lunch: 1 unit of insulin per _____ grams of carbohydrate
- Afternoon Snack: 1 unit of insulin per _____ grams of carbohydrate

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

Totally independent management.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Self injects with trained staff supervision.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tests blood sugar independently.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Injections to be done by trained staff.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tests and interprets urine/blood ketones.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Self treats mild hypoglycemia.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Needs verification of blood sugar by staff.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monitors own snacks and meals.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Administers insulin independently.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Independently counts carbohydrates.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Self injects with verification of dose.	<input type="checkbox"/> Yes <input type="checkbox"/> No		

SIGNATURES

Parent _____ Date _____

Physician _____ Date _____ Phone _____ Fax _____

 School Health Nurse Review: _____ Date: _____