Physician/ARNP/PA Orders for Student with Diabetes

Physician/ARNP/PA to complete.

Student's Name: _____ Date of Birth: _____
Physical Condition: ❑ Diabetes Type 1 ❑ Diabetes Type 2 ❑ Dysmetabolic Syndrome/Prediabetes

BLOOD GLUCOSE MONITORING

Target range for blood glucose (BG) is: ☐ 70-140 ☐ 70-180 ☐other _____
Times to check blood glucose:
☐ Before breakfast ☐ 2 hours after breakfast ☐ Before lunch ☐ 2 hours after lunch ☐ Before exercise
☐ After exercise ☐ When student exhibits symptoms of hypoglycemia or hyperglycemia

Ketone Testing

Check urine with ketone strip if blood sugar is greater than 300 mg/dL.
No exercise until ketones are eliminated and blood glucose (BG) is less than 300.
Notify Physician if urine ketones are: ☐ present ☐ moderate amt. ☐ large amt ☐ do not notify

Restrictions on activity
Student should not exercise if blood glucose level is below_____ mg/dl or above _____mg/dl.

ORDERS FOR MEDICATION

Oral Diabetes Medications ☐ Not Applicable
Type of medication: _____ Dosage_____ Frequency_____

Insulin Orders: ☐ Not Applicable ☐ Vial and Syringe or
Insulin Pen: ☐ Luxura; ☐ Humalog Disposable; ☐Novolog Jr.; ☐ Novolog Flexpen; ☐ Apidra Solostar; ☐Other:_____
Breakfast: _____units OR
_____units/_____carb/calorie (circle)

Lunch: _____units OR
_____units/_____carb/calories (circle)

Insulin Correction/Supplemental Dose for Hyperglycemia: ☐ None ordered
In addition to care plan treatment for hyperglycemia i.e. fluids, activity restrictions
Give Insulin Correction Dose: ☐Before Breakfast ☐Before Lunch ☐Before Dinner ☐***Hyperglycemia Supplemental Dose**
If BS is _____ to _____ mg/dl give ____ units of insulin If BS is _____ to _____ mg/dl give ____ units of insulin
If BS is _____ to _____ mg/dl give ____ units of insulin If BS is _____ to _____ mg/dl give ____ units of insulin
Additional Orders_____
***BG should be re-checked _____ minutes after Hyperglycemia Supplemental Insulin is administered.**

Insulin Pumps ☐ Not Applicable ☐ Follow pump orders as prescribed by specialist/endocrinologist
Type of pump: _____ Type of Insulin in pump_____
Type of infusion set: _____ Algorithm available? ☐ yes ☐ no
Insulin to carbohydrate ratio: _____ Sensitivity: _____ Bolus Range: _____
Basal rates: Rate: ___ time: ___ to ___ Rate: ____ Time:___ to ___ Rate: ____ Time:___ to ___ Rate: ____Time:___ to ___

Correction for Hypoglycemia – treat when BG is below _____ Treatment _____
Recheck Blood Glucose 15 minutes following oral treatment.
If blood glucose is still below 70, may repeat oral treatment and recheck blood glucose again in 15 minutes.
* **If blood glucose is still below 70,** repeat oral treatment and notify a parent or parent designee and care for him/her until blood glucose has been above 90 for at least 1 ½ hours.
* **If blood glucose is above 70,** follow with a protein snack. Pupil may return to class if he/she is not experiencing any symptoms of hypoglycemia.
Glucagon ☐ Yes ☐ No To be used if student is unconscious, having a seizure, or unable to swallow and call 911.
☐ 1/2 mg; ☐ 1 mg To be administered sub-q by trained unlicensed personnel or IM by school nurse
Additional Orders: _____

PHYSICIAN/ARNP/PA SIGNATURE: _____ DATE: _____
Print Name: _____ Physician Phone Number:_____

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Emergency number: _____

Parents Information for Development of Diabetes Health Care Plan

Parent/Guardian/Student to Complete before giving to Physician

Student's Name: _____ Date of Birth: _____ Grade: _____

Physical Condition: ❑ Diabetes Type 1 ❑ Diabetes Type 2 ❑ Dysmetabolic Syndrome/Prediabetes

Contact Information

Mother/Guardian: _____ Daytime phone: _____ Cell _____

Father/Guardian: _____ Daytime phone: _____ Cell _____

Other Emergency Contacts:

Name: _____ Relationship: _____

Daytime phone _____ Cell _____

STUDENT SELF-MANAGEMENT	YES	NO	NEEDS ASSISTANCE
Has student done his/her own blood glucose checks?			
Has student been giving own insulin? ☐sub-q injection ☐pump			
Able to perform blood glucose checks? Meter student uses:			
Able to calculate Carbohydrates (Carbs)/Calories?			
Prepare reservoir and tubing for pump?			
Troubleshoots alarms and pump problems?			

Meal Planning Information:

Usual carbs/calories: Breakfast _____ Mid-morning snack _____ Lunch _____ Mid-afternoon snack _____

Snack before exercise? ☐yes ☐no # of Carbs _____ Snack after exercise? ☐yes ☐no # of Carbs _____

Foods to avoid, if any: _____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):_____

_____

Insulin Pump Information: if applicable

Type of pump: _____ Type of Insulin in pump_____ Type of infusion set: _____

Algorithm available? ☐yes ☐no Insulin to carbohydrate ratio:_____ Sensitivity: _____

Bolus Range: _____ Basal rates: (___ ___ to ___) (___ ___ to ___) (___ ___ to ___) (___ ___ to ___)

Exercise/Sports and Field Trips

When he/she participates, a fast-acting carbohydrate such as _____ should be immediately available.

Parent Notification

Notify parent if urine ketones are present. ____yes ____no

Notify parent when or if supplemental/correction insulin given. ___yes ____no

Parent/guardian will be notified if student refuses medication, appropriate testing and/or intervention for abnormal blood sugar.

Supplies to be Kept at School

❑Insulin or oral medications ❑Urine ketone strips ❑Blood glucose meter and testing supplies

❑Glucagon emergency kit ❑Fast-acting source of glucose ❑Insulin pump and supplies

❑Insulin pen, pen needles, insulin cartridges ❑Carbohydrate containing snack ❑Reservoir, infusion sets, etc.

❑Other (list)

TO BE COMPLETED BY THE PARENT/GUARDIAN: I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ school to perform and carry out the diabetes care tasks as ordered by the physician. I also consent to the release of the information to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I permit my child to manage his/her diabetic care and self-administer medication as approved by the school nurse and ordered by the physician.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

SELF MANAGEMENT CONSENTS:

TO BE COMPLETED BY SCHOOL NURSE

The student demonstrated appropriate use, knowledge and skills of testing tools, equipment and medications to manage his/her diabetic care as ordered by physician.

SCHOOL NURSE SIGNATURE _____

DATE: _____

TO BE COMPLETED BY STUDENT

I have been instructed in the proper use of monitoring tools, equipment and medication. I will manage my diabetes and administer medications as prescribed by my physician.

STUDENT SIGNATURE _____

DATE: _____

Additional Resource Information: National Diabetes Education Plan: http://ndep.nih.gov/