

Health Care Provider Orders for Student with Diabetes on Injections/Oral Medication

To be completed by the Health Care Provider and used in conjunction with the Standards of Care for Diabetes Management in the School Setting – Colorado
www.coloradokidswithdiabetes.org

Student:	DOB:	School:	Grade:
Physician/Provider:	Phone:		
Diabetes Educator:	Phone:		

TARGET RANGE – Blood Glucose:	mg/dl	TO	mg/dl	
<input type="checkbox"/> < 5y.o. 80-200mg/dl	<input type="checkbox"/> 5 – 8 y.o. 80-200mg/dl	<input type="checkbox"/> 9-11y.o. 70-180mg/dl	<input type="checkbox"/> 12-18y.o. 70-150mg/dl	<input type="checkbox"/> >18y.o. 70-130mg/dl
Notification to Parents: Low < <u>target range</u> and High > 300 mg/dl or Other: less than <u> </u> mg/dl and greater than: <u> </u> mg/dl				
<input type="checkbox"/> Continuous glucose monitoring: Always Confirm glucose level with a fingerstick/meter prior to treatment unless student has a Dexcom G5 or G6, it may be used for dosing and treatment. Please follow Collaborative Guidelines for Dexcom G5 & G6: Therapeutic Dosing in the School Setting (www.coloradokidswithdiabetes.org)				

Hypoglycemia: Follow Standards of Care for Diabetes Management in the School Setting – Colorado, unless otherwise indicated here: _____		
For Severe Symptoms: Call 911 & Administer Glucagon Dose:	mg	Intramuscular in <input type="checkbox"/> Arm <input type="checkbox"/> Buttocks <input type="checkbox"/> Thigh
Hyperglycemia: Follow Standards of Care for Diabetes Management in the School Setting – Colorado, unless otherwise indicated here: _____		
Ketone Testing: per Standards of Care for Diabetes Management in the School Setting – Colorado OR Other:		Other: _____

When to Check Blood Glucose: For provision of student safety while limiting disruption to learning
<input type="checkbox"/> Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns
<input type="checkbox"/> Check before meals and as mutually agreed upon by parent and school nurse
<input type="checkbox"/> Other: _____

Blood Glucose Correction and Insulin Dosage Using (Rapid Acting/Short Acting) Insulin Type:	<i>Injections should be given subcutaneously & rotated</i>
Lunchtime Correction: Give <input type="checkbox"/> Prior to lunch <input type="checkbox"/> Immediately after lunch <input type="checkbox"/> Split ½ before lunch & ½ after lunch <input type="checkbox"/> Other :	
<input type="checkbox"/> Insulin Dosing Attached	
<input type="checkbox"/> Sensitivity/Correction Factor:	_____ unit insulin for every _____ mg/dl above _____ starting at _____ mg/dl
Blood Glucose Range:	mg/dl to mg/dl Administer: units <input type="checkbox"/> Check ketones
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<input type="checkbox"/> Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin per Guidelines for Insulin Management*	
When hyperglycemia occurs other than at lunchtime:	
<input type="checkbox"/> If it has been greater than 3 hours since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders if approved by the school nurse and parent is notified.	
<input type="checkbox"/> Contact Health Care Provider for One-time order	

Carbohydrates and Insulin Dosage: <input type="checkbox"/> Breakfast <input type="checkbox"/> Snack <input type="checkbox"/> Lunch <input type="checkbox"/> Other:
(To be given in conjunction with the correction dose as indicated)
Insulin to Carbohydrate Ratio: _____ unit(s) for every _____ grams of carbohydrate to be eaten <input type="checkbox"/> Dosing Attached
<input type="checkbox"/> Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

<input type="checkbox"/> Oral Medication: _____ mg Time: _____
<input type="checkbox"/> NPH Insulin Dose: _____ units SQ Time: _____
Student's Self Care: <input type="checkbox"/> No supervision <input type="checkbox"/> Full supervision, <input type="checkbox"/> Requires some supervision: ability level to be determined by school nurse and parent unless otherwise indicated here:
Additional Information:
Signatures: My signature below provides authorization for the written orders above and exchange of health information to assist the school nurse 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: _____