HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN
STUDENT WITH DIABETES USING INSULIN **PUMP**   (MONTANA FORM VERSION 3/23/2015)

EFFECTIVE DATE:	End Date:
STUDENT'S NAME:	Date of Birth:

DIABETES HEALTHCARE PROVIDER INFORMATION   Name:

Phone #:   Fax #:   Email:

SCHOOL: School Fax:

⇨**See accompanying Algorithm for Blood Glucose Results as supplement to these orders*****

Monitor Blood Glucose – ☒ Check as needed if student has symptoms of high or low blood glucose or does not feel well

☐ Before lunch   ☐ Other: _____
☐ Before PE   ☐ Other: _____
☐ Before leaving school   ☐ Other: _____

Where to check: ☐ Anywhere   ☐ Classroom   ☐ Health office   ☐ Other: _____

Insulin Pump Information: ☐ *Humalog or NovoLog or Apidra by pump*   ☐ Other: _____

Carbohydrate Coverage:

Give 1 unit of insulin per:
_____ gm carbohydrate at breakfast
_____ gm carbohydrate at AM snack
_____ gm carbohydrate at lunch
_____ gm carbohydrate at PM snack

Bolus should occur: ☐ before eating, or
                     ☐ other: _____

Correction Bolus for Hyperglycemia:

All blood glucose results should be entered into pump.

Times given: ☐ Before am snack   ☐ Before lunch
              ☐ Before pm snack   ☐ Use pump suggested correction
              ☐ Other: _____
              _____

Give 1 unit of insulin for every _____ mg/dl, with a target blood glucose of _____ mg/dl.

Formula used to calculate correction:

Blood glucose _____ minus (-) target blood glucose _____ = _____.
Then divide (÷) by correction factor (_____) = _____.

Check Ketones if nauseated, vomiting or has abdominal pain, or if blood glucose > 300 twice when tested 2-3 hours apart.

☐ Use correction formula <u>via syringe/pen.</u>

☐ Use correction formula <u>via syringe/pen,</u> and give an additional _____ units of insulin for moderate ketones, and _____ units for large ketones.

*** Repeat ketone check in 2 hours, and repeat additional insulin if moderate or large ketones are still present.

* Basal insulin will be running continuously during school. Notes: _____

* If infusion set comes out or needs to be changed: ☐ Insulin via syringe every 3 hours   ☐ Change set at school

Moderate Exercise (lasting 30 minutes or more) and Sports with Pump:

Temporary Basal Decrease: ☐ No   ☐ Yes (_____% for _____ minutes OR ☐ for duration of exercise)
Student should monitor blood glucose hourly or when there are signs/symptoms of low/high blood glucose.

Diabetes Medications:

☐ **Glucagon (for emergency low blood glucose)** - Dose: ☐ 0.5 mg ☐ 1.0 mg   Given IM or SC per thigh or arm

☐ Medication: _____ Dose: _____ Times to be given: _____
☐ Medication: _____ Dose: _____ Times to be given: _____

HCP Assessment of Student's Diabetes Management Skills:

Skill	Independent	Needs supervision	Cannot do
Check blood glucose			
Count carbohydrates			
Deliver insulin bolus			
Change infusion set			
Calculate dose & inject			
Trouble shoot alarms, malfunctions			

☐ Student may advance in independence through school year if school/parent agrees.

Parent/Guardian Authority:

* To adjust insulin dose: ☐ Yes ☐ No
* To change frequency of blood glucose monitoring: ☐ Yes ☐ No

<u>Notes:</u>

HEALTHCARE PROVIDER SIGNATURE/STAMP:	Date:
PARENT/ GUARDIAN SIGNATURE:	Date:

UPDATES TO THE
HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN
STUDENT WITH DIABETES USING INSULIN **PUMP**

STUDENT'S NAME:	Date of Birth:
DIABETES HEALTHCARE PROVIDER INFORMATION Name: Phone #: Fax #: Email:	
SCHOOL:	School Fax:

Effective Date: **Update:**

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	