SIGNATURE PREPARATORY

DIABETES MEDICAL ORDERS

CAMPUS: _____ SCHOOL YEAR: 20_____/20_____

STUDENT: _____ GRADE _____ TEACHER _____

BLOOD GLUCOSE TARGET RANGE: _____ mg/dl to **_____ mg/dl**

Blood Glucose Testing: ❑ independent ❑ needs assistance

___ before AM snack
___ before lunch
___ before after-school sports
___ when student feels low/high or ill
___ other times _____
___ if BG is less than _____ mg/dl or BG is greater than _____, call parent.

Comments: _____

For BG, lower than _____ or over ____ see Hypoglycemia Emergency Care Plan or DMMP

Urine Ketones Testing: ___ For BG greater than ____ mg/dl, do ketone testing.

If ketones are positive, contact parent and encourage sugar-free fluids.

Insulin Injection or Pump Bolus: ❑ independent ❑ needs assistance

Type of Insulin _____
___ Always call parent for dose.
___ Bolus for meal, based on carbohydrate count.
___ Correction or supplemental bolus for high BG

Comments: _____

For Students with Insulin Pump:

Type of pump: _____
Does student need assistance with pump skills? ❑ Yes ❑ No

Comments: _____

Seizure, Unable to Swallow and/or Loss of Consciousness:

___ Glucose gel and **call 911.**
___ Glucose gel, 1 mg of Glucagon IM or SQ and **call 911.**

I give my permission for the school to contact my health care provider, _____, at (___) ____-_____ (phone#) regarding the treatment of my child's diabetes.

Parent/Guardian Signature: _____ Date: _____