

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 \_\_\_\_\_

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 1/2 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: \_\_\_\_\_

**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? <input type="checkbox"/> sub-q injection <input type="checkbox"/> 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: \_\_\_\_\_