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**			
☐< 5y.o. 80-200mg/dl	☐ 5 – 8 y.o 80-200mg/dl	☐ 9-11y.o 70-180mg/dl	☐ 12-18y.o. 70-150mg/dl	☐ >18y.o. 70-130mg/dl

Notification to Parents: Low < *target range* and High > 300 mg/dl or ***Other:*** less than______**mg/dl** and greater than:______**mg/dl**

☐ 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** ☐**Arm** ☐**Buttocks** ☐**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*

Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns

Check before meals and as mutually agreed upon by parent and school nurse

☐ **Other:**

Blood Glucose Correction and Insulin Dosage Using (Rapid Acting/Short Acting) Insulin Type: *Injections should be given subcutaneously & rotated*

Lunchtime Correction: Give ☐ Prior to lunch ☐ Immediately after lunch ☐ Split ½ before lunch & ½ after lunch ☐ Other :

☐**Insulin** Dosing Attached

☐**Sensitivity/Correction Factor:** ______ unit insulin for every ______mg/dl above ___________starting at ______mg/dl

Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones

☐ 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:

☐ 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.**

☐ **Cont**act Health Care Provider for One-time order

Carbohydrates and Insulin Dosage: ☐ **Breakfast** ☐**Snack** ☐**Lunch** ☐**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 ☐Dosing Attached

☐ Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

☐ **Oral Medication:** ______ ______mg Time: ______

☐ **NPH Insulin** Dose: ______units SQ Time: ______

Student's Self Care: ☐No supervision ☐Full supervision, ☐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: ____________________________