Maryland State Management of Diabetes at School/Order Form

This order is valid only for the Current School Year: _____(including summer session)

Student: _____ **DOB:** _____
School: _____ **Grade:** _____

CONTACT INFORMATION

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____

Other Emergency Contact: _____

Insulin Orders (complete only if insulin is needed at school):

1. Insulin administration via:

Syringe and vial Insulin pen Insulin pump Other _____

Insulin pump Type of pump: Basal rates:

2. Insulin Before Lunch/Meals: Name of Insulin: _____

Routine lunchtime dose: _____

Per sliding scale as follows:

Meals

Blood Glucoseto	_____	_____	give	_____ units
Blood Glucoseto	_____	_____		_____
Blood Glucoseto	_____	_____		_____
Blood Glucoseto	_____	_____		_____
Blood Glucoseto	_____	_____		_____
Blood	_____	_____	Glucoseto	_____
give	_____	_____	units	Blood
Glucoseto	_____	_____	give	units
Blood Glucoseto	_____	_____	give	units
Blood Glucoseto			give	units
Blood Glucoseto	_____	_____	give	units
Blood Glucoseto	_____	_____	give	units
Blood Glucoseto	_____	_____	give	units
Blood Glucoseto	_____	_____		

Calculated insulin dose (**add** carbohydrate coverage and correction dose for total insulin dose):

Carbohydrate Coverage: Insulin to carbohydrate ratio Give _____ # unit(s) insulin per_____gms carbohydrate.

Correction:

Give _____ # unit(s) insulin per_____ mg/dl of glucose **above** _____ mg/dl

Subtract _____ # units for every _____mg/dl of glucose **below** _____mg/dl

Insulin may be given after lunch if _____

3. Other times insulin may be given:

Snack: Dose: _____ Calculated as above.

Ketones: If ketones are _____Give/Add: _____unit(s)

If ketones are _____Give/Add: _____unit(s)

Snack:

Blood Glucose Give: _____ units

_____ units

_____ units

Health Care Provider Authorization for Management of Diabetes in School

My signature below provides authorization for the above written orders. This authorization is for a maximum of one school year. If changes are indicated, I will provide new written authorization, which may be faxed.

Health Care Provider Name: _____ **Signature:** _____(original or stamped signature) ***Sign both sides.**

Address: _____ **City:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Date:** _____

Use for Prescriber's Address Stamp

Parent Consent for Management of Diabetes at School

I (We) request designated school personnel to administer the medication and treatment orders as prescribed above. I agree

1. To provide the necessary supplies and equipment
2. To notify the school nurse if there is a change in the student's diabetes management or health care provider.

I authorize the school nurse to communicate with the health care provider as necessary.

Parent/Guardian Signature _____ Date _____ ***Sign both sides.**

_____ Date _____

Order reviewed and signed by School Nurse (per local policy): Date:

Student: _____

Blood Glucose Monitoring:

Target range for blood glucose monitoring at school: _____

Before snacks 2 hours or _____hours after lunch

Before meals 2 hours or _____hours after a correction dose

As needed for symptoms of hypo/hyperglycemia

With signs and symptoms of illness

Other times: _____

Hypoglycemia – blood glucose less than _____

Self treatment for mild lows.

Give _____grams of fast-acting carbohydrateaccording to care plan. Recheck BG in 10-15 mins. Repeat treatment if BG less than ___mg/dl Provide extra protein & carbohydrate snack after treating low if next meal/snack greater than ____minutes away Suspend pump for severe hypoglycemia for _____mins.

If student is unconscious, having a seizure or unable to swallow, presume student is having a low blood sugar and:

Call 911, notify parent

Glucagon injection (1 mg in 1 cc) _____ mg, subcutaneously or intramuscular (IM)

OK to use glucose gel inside cheek, even if unconscious, seizing.

Other: _____

Hyperglycemia – blood glucose greater than _____

Check urine ketones, follow care plan, administer insulin as per orders. For pumps, insulin may be given by syringe or pen if needed.

Encourage sugar free fluids, at least ____ounces per _____.

If student complains of nausea, vomiting or abdominal pain; check urine ketones & check insulin administration orders.

Other: _____*

Transport to local Emergency Room may be needed with vomiting and large ketones.

Meal Plan

AM snack, time: _____ PM snack time: _____ Avoid snack if blood glucose greater than _____ mg/dl. Lunch: _____

Extra food allowed; Parent's discretion; Student's discretion

Exercise (check and/or complete all that apply)

Fast-acting carbohydrate source must be available before, during and after all exercise.

With student With teacher

If most recent blood glucose is less than _____, exercise can occur when blood glucose is corrected and above _____.

Eat _____grams of carbohydrate Before Every 30 mins during After vigorous exercise

Avoid exercise when blood glucose is greater than _____or ketones are _____

Bus Transportation

Blood glucose monitoring not required prior to boarding bus

Check blood glucose 15 minutes prior to boarding bus

Allow student to eat on bus if having symptoms of low blood glucose

Provide care as follows: _____

Health Care Provider Assessment

Student can self-performthe following procedures (school nurse and parent must verify competency):

Blood glucose monitoring Measuring insulin Injecting insulin Determining insulin dose

Independently operating insulin pump

Other: _____

Disaster Plan (if needed for lockdown, 24 hr shelter in place)**:**

Follow insulin orders as on Management Form

Additional insulin orders as follows: _____

Administer long acting insulin as follows: _____

Other: _____

Other instructions:

_____

Health Care Providers Signature: _____ Phone: _____ Date: _____

Parent's Signature: _____ Phone: _____ Date: _____

Order reviewed by School Nurse (per local policy): _____ Date: _____

Maryland State Supplemental Form for Students with Insulin Pumps

This order is valid only for the Current School Year: _____ (including summer session)

Student: _____ **DOB:** _____ **School:** _____ **Grade:** _____

CONTACT INFORMATION:

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____
Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____
Pump Resource Person: _____ Phone: _____
Other Emergency Contact: _____

Pump Management

Type of pump: _____ Start Date for Pump Therapy: _____ Type of Insulin in pump: _____

Basal rates: _____ 12am to _____ Comment: _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Insulin/carbohydrate ratio: _____ Check Management of Diabetes at School Order or correction factor
Hyperglycemia:

_____ Pump site should be changed if BG greater than _____ times _____
_____ Insulin should be given by syringe or pen if needed _____

Management Skills of Student

- As verified by school nurse, health care provider and parent

		Independent?
Count carbohydrates	__yes	__no
Calculate an insulin dose	__yes	__no
Bolus an insulin dose	__yes	__no
Reset basal rate profiles	__yes	__no
Set a temporary basal rate	__yes	__no
Disconnect pump	__yes	__no
Reconnect pump at infusion set	__yes	__no
Prepare infusion set for insertion	__yes	__no
Insert infusion set	__yes	__no
Troubleshoot alarms and malfunctions	__yes	__no
Give self injection if needed	__yes	__no
Change batteries	__yes	__no

___ Student is non-independent Child Lock On? Yes No

Pump Supplies

Extra supplies needed include: Infusion sets, reservoir/cartridges, insertion device, insulin vial & syringes, batteries
Location of supplies: _____

Disaster Plan (If needed for lockdown, etc):

Follow Insulin orders as on Management Form
Insulin doses as follows: _____
Other: _____

Health Care Provider's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

Order reviewed by School Nurse (per local policy): **Date:** _____