EL PASO COUNTY SCHOOL HEALTH SERVICES
PRACTITIONER'S WRITTEN ORDER/DIABETES ACTION PLAN

I. Physician Section

Student Name _____ DOB _____ ID# _____ Grade _____

School Year 20 _____ -20 _____ School Name _____

DIAGNOSIS: Diabetes Type I ☐ Diabetes Type II ☐ Gestational Diabetes ☐

This plan should be completed by the student's physician and parent/guardian. It should be reviewed with all relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, unlicensed diabetes care assistants and other authorized personnel.

BLOOD GLUCOSE MONITORING: **Target blood glucose**: _____ mg/dl

Target range for blood glucose: _____ mg/dl to _____ mg/dl Usual times to test blood glucose: _____

Time to do extra tests (check all that apply): _____ Before exercise When student exhibits symptoms of hyperglycemia

_____ After exercise _____ When student exhibits symptoms of hypoglycemia

_____ Other (explain): _____

_____

Can student perform own blood glucose test? ☐YES ☐NO Exceptions: _____

INSULIN:

Time: _____ Type of Insulin: _____ Dose: _____

Time: _____ Type of Insulin: _____ Dose: _____

If Flexible dosing is used:

Time: _____ Type of Insulin: _____ Dose: _____ Units/ _____ grams of carbohydrates

Can student give own injections? ☐YES ☐NO Exceptions: _____

Can student determine correct amount of insulin? ☐YES ☐NO Can student draw correct dose of insulin? ☐YES ☐NO

Insulin Correction Dose: Dose: Give _____ unit of _____ insulin SQ for blood glucose _____ mg/dl above _____ mg/dl or

Blood glucose below _____ mg/dl = no additional insulin

_____ Units of _____ Insulin subcutaneously if blood glucose is _____ To _____ mg/dl

_____ Units of _____ Insulin subcutaneously if blood glucose is _____ To _____ mg/dl

Notify **parent** if blood glucose is over _____ mg/dl Notify **MD** if blood glucose is over _____ mg/dl

INSULIN PUMPS:

Basal rates: _____ _____ 12 am to _____

Type of Insulin in Pump: _____ Type of infusion Set: _____

Insulin/Carbohydrate Ratio: _____ Correction Factor: _____

Is student competent regarding pump? ☐YES ☐NO Can student effectively troubleshoot problems? ☐YES ☐NO

FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS:

Time: _____ Name of Medication: _____ Dose: _____

Time: _____ Name of Medication: _____ Dose: _____

UNABLE TO SWALLOW, LOSS OF CONSCIOUSNESS, OR SEIZURE:

☐ Glucose gel, 1mg of Glucagon IM or Sub-Q and Call 911.

EXERCISE AND SPORTS:

Restrictions on activity, If any: _____

Students should **not** exercise if blood glucose is below _____ mg/dl or above _____ mg/dl or if moderate to large amounts of ketones are present.

Follow Management Instructions for Low and High Blood Sugar on Page 2

THIS DIABETES MEDICAL MANAGEMENT PLAN HAS BEEN APPROVED BY:

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHONE NUMBER: _____ FAX NUMBER: _____

NAME OF PHYSICIAN'S DIABETES EDUCATOR: _____ NUMBER: _____

Hypoglycemia: (Low Blood Sugar)

1. If blood glucose is below 70 mg/dl:
   A. Give child 15 grams of carbohydrates, such as 15 Skittles (each Skittle is 1 gm), 6 oz. of regular soda, 4 oz. of juice, 3-4 glucose tabs.
   B. Allow child to rest for 10-15 minutes and retest blood glucose.
   C. If glucose is above 70 mg/dl, allow student to proceed with scheduled meal, snack or school activities.
   D. If symptoms persist or blood glucose remains below 70 mg/dl, repeat A & B.
   E. If symptoms still persist, notify parent and keep child in clinic.
2. If blood glucose is below 70 mg/dl and the child is unconscious, seizing or unable to swallow:
   A. Activate emergency medical services.
   B. Rub a small amount of glucose gel or cake frosting on child's gums and oral mucosa.
   C. If available, inject Glucagon 1 mg subcutaneously.
   D. Notify parent.

Insulin Pump
If the child uses an insulin pump, the pump should be disconnected if loss of consciousness or seizures occurs. Do not pull the insertion set out; just disconnect the catheter tubing from the insertion set.
If the student wears an insulin pump, the basal rate may be stopped for 30 minutes to help the glucose numbers come up more quickly. This is done by setting the temporary basal rate at 0% for 30 minutes or the pump can be disconnected.
If the pump was disconnected, reconnect the pump once the glucose level is over 70 mg/dl.

Hyperglycemia: (High Blood Sugar)

Urine or blood ketones should be tested when blood sugar is over 250 mg/dl or when student is ill.
1. If small or trace amounts of ketones are present, encourage water until ketones are negative. Recheck blood glucose every 2-3 hours.
2. If moderate or large amounts of ketones are present:
   A. Student should remain in clinic for monitoring while waiting for parent pick up.
   B. Notify parent for pick up.
   C. Give 1-2 glasses of water every hour.
   D. While student is waiting for parent pick up, retest blood glucose and ketones every 2-3 hours or until ketones are negative.
   E. While waiting for parents to pick up the student, the student needs to drink as much water as he/she can (1-2 glasses or water every hour).
   F. Rapid acting insulin (Humalog/Novolog/Apidra) doses need to be given every 2-3 hours, fluids need to be encouraged and glucose levels need to be checked every 2 hours per physician or parent guidelines until urine ketones clear.

Insulin pump
If the child is on an insulin pump, these additional guidelines may also be necessary. Because only short acting insulin is used in insulin pumps, if something happens to the delivery of insulin to the student, he/she can go into ketoacidosis relatively quickly. Therefore, if the student has two high glucose readings twice in a row, the student needs an injection of insulin with a syringe (the dose based on glucose levels). If the glucose level is over 250 mg/dl and ketones are not present in the urine, a bolus via the pump needs to be given and the glucose number needs to be rechecked in 2 hours.
If that 2nd number is over 250 mg/dl, the parents need to be notified and the insulin pump cartridge, tubing and infusion set needs to be changed. If there are ketones (moderate to large) in the student's urine at any time, the parents need to be notified.
If ketones are present, then the pump cartridge, tubing and infusion set needs to be changed, after an injection of insulin is given to the student, based on the glucose level and the amount of ketones present. Notify parents as soon as possible.
If the parents cannot be contacted and the student is vomiting, breathing heavily or the breath smells like ketones, Call 911.

II. Parent/Guardian Section

Student Name _____ DOB _____

School _____ ID# _____ Grade _____

CONTACT INFORMATION:

Parent/Guardian #1: _____ Address: _____

Telephone-Home: _____ Work: _____ Cell Phone: _____

Parent/Guardian #2: _____ Address: _____

Telephone-Home: _____ Work: _____ Cell Phone: _____

Other Emergency Contact: _____ Relationship: _____

Telephone-Home: _____ Work: _____ Cell Phone: _____

Student's Doctor/Health Care Provider: _____ Telephone: _____

Does the student wear a medical alert bracelet/necklace? ☐YES ☐NO

PARENT AUTHORIZATION SIGNATURE:

As parent/guardian of the above named student, I give permission for use of this health plan and for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

I also give permission to the School Nurse, the Unlicensed Diabetes Care assistant (UDCA) and any other designated staff members of my child's school to perform and carry out the diabetes care tasks as outlined by child's Diabetes Management and Treatment Plan. I also consent to the release of the information contained in this Diabetes Management Treatment Plan to all 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 agree to provide the school with all the supplies and medication(s) necessary to carry out the treatment plan for my child as indicated by my child's physician/healthcare provider.

I also agree to notify the school should there be any changes to my child's treatment plan at any time throughout the school year.

PARENT/GUARDIAN SIGNATURE: _____DATE: _____

My child is knowledgeable in the management of his/her diabetes and it is my wish that he/she be allowed to manage his/her diabetes independently while at school or at an off campus event. My child will seek assistance from the school nurse or diabetes care attendant as needed or in the event of a medical emergency.

PARENT/GUARDIAN SIGNATURE: _____DATE:_____

STUDENT SIGNATURE: _____DATE:_____

This diabetes management plan has been read and reviewed by the school nurse and/or unlicensed diabetes care attendant.

School Nurse Signature: _____DATE:_____

Unlicensed Diabetes Care Assistant Signature: _____DATE:_____

II. SECCION DEL PADRE/TUTOR

Nombre del Estudiante _____ Fecha de Nacimiento _____

Escuela _____ # de Identificacion _____ Grado _____

INFORMACION DE CONTACTO:

Padre/Tutor #1: _____ Domicilio: _____

Telefono-Casa: _____ Trabajo: _____ Celular: _____

Padre/Tutor#2: _____ Domicilio: _____

Telefono-Casa _____ Trabajo: _____ Celular: _____

Otro Contacto de Emergencia: _____ Relacion: _____

Telefono-Casa: _____ Trabajo: _____ Celular: _____

Medico del Estudiante _____ Telefono: _____

¿El estudiante usa una pulsera/collar de alerta médica? ☐Si ☐NO

FIRMA DE AUTORIZACION DEL PADRE:

Como padre/guardián del estudiante nombrado arriba, doy permiso para el uso de este plan de salud y a la enfermera de la escuela para contactar al proveedor profesional de salud de mi hijo con respecto a la condición mencionada anteriormente.

También doy permiso a la enfermera, la asistente de cuidado de la Diabetes sin licencia (UDCA) y cualquier otros miembros del personal designado de la escuela de mi hijo/a a realizar y llevar a cabo las instrucciones de cuidado de la diabetes como indicado en el Plan de tratamiento y manejo de la Diabetes de mi hijo/a. También doy mi consentimiento para la publicación de la información contenida en este Plan de tratamiento y manejo, a todos los miembros del personal y otros adultos que tienen el cuidado custodial de mi hijo/a y que necesitan saber esta información para mantener la salud y seguridad de mi hijo/a.

Estoy de acuerdo en proveer a la escuela con todos los suministros y medicamentos necesarios para llevar a cabo el plan de tratamiento para mi hijo/a como lo indica el médico.

También estoy de acuerdo en notificar a la escuela si existen cambios al plan de tratamiento de mi hijo/a en cualquier momento a lo largo del año escolar.

FIRMA DEL PADRE/TUTOR: _____FECHA: _____

Mi niño es experto en el manejo de su diabetes y es mi deseo que él o ella puede manejar independientemente su diabetes en la escuela o en un evento escolar. Mi hijo buscará ayuda de la enfermera o asistente de cuidado de la diabetes sin licencia, según sea necesario o en caso de una emergencia médica.

FIRMA DEL PADRE/TUTOR: _____FECHA :_____

FIRMA DEL ESTUDIANTE: _____FECHA:_____

This diabetes management plan has been read and reviewed by the school nurse and/or unlicensed diabetes care assistant.

School Nurse Signature: _____DATE:_____

Unlicensed Diabetes Care Assistant Signature: _____DATE:_____