

Diabetes Orders

Student's Name _____ DOB _____

School _____

Physician _____ Effective Date _____

Type of insulin: (circle one) Rapid or Short Acting: Apidra/Humalog/Novolog/Regular

Intermediate or Long-acting given at home: (circle one) NPH/Lantus/Levemir

Insulin to carbohydrate ratio (I:CR): _____ units/ _____ grams or Fixed insulin lunch dose _____

Parent may adjust I:CR by +/- 1 to 5 grams Yes/No (circle one)

Correction Factor (CF) (insulin sensitivity): CF: _____ units per _____ mg/dl over _____ mg/dl

(Correction Factor Formula: Student's BG minus Target BG ÷ correction factor = insulin dose)

Usual Insulin Dose Range _____. Target blood glucose range: 70-110 pre-meal. Other: _____

Insulin Pump: (if applicable)

Type: _____

Basal Rates:	Time:	Rate (units per hr)
	12:00 am =	_____
	_____	_____
	_____	_____
	_____	_____

Blood Glucose Monitoring (in classroom if possible) or

Location _____

Before am snack _____
Before lunch _____
Before exercise _____
After exercise _____
Signs of low or high blood sugar _____
Other _____

Child is able to:

(Circle all that apply)

Test own glucose	Yes/No
Determine insulin dose	Yes/No
Draw up insulin	Yes/No
Administer insulin dose	Yes/No
Manage/troubleshoot pump	Yes/No

Exercise and Sports

Student **should not** exercise if blood glucose is

BG is below _____ mg/dl or
above _____ mg/dl
Snack before exercise Yes/No
Snack after exercise Yes/No

Meals/ Snacks:

Breakfast _____
A.M. Snack _____
Lunch _____
P.M. Snack _____
Food in class, e.g. party _____

Supplies to be provided by parents: Blood Glucose Monitor and all monitoring supplies, Insulin and administration supplies, Glucagon emergency kit, snack foods, fast-acting glucose source, Ketone testing supplies, Insulin pump supplies if appropriate.

High blood glucose Management/Preventing Diabetic Ketoacidosis

If BG is above 250 mg/dl, wash hands and recheck. If still above 250:

→ If less than 2 hrs since last dose of Apidra, Humalog or Novolog, *recheck at 2 hrs after the last dose and continue as below.

→ If 2 hrs or more since the last dose of Apidra, Humalog, or Novolog* give a correction dose using the correction factor formula.

→ Check urine for ketones. If positive, drink 6-8 oz liquid with no calories every 30 minutes (e.g. water, diet soda)

→ If moderate or large ketones at any time, call parent.

→ Check BG and ketones every 2 hrs and give correction dose until BG reaches target range and ketones clear.

→ If BG and ketones are not decreasing after 4 hrs, call parent.

Additional Instructions for Insulin Pump Users:

→ If ketones are negative, check pump and site. If okay, give correction bolus by pump.

→ If ketones are positive, give correction bolus by syringe (not by pump) and have student change infusion set/site if able or call parent.

→ If initial correction bolus was given by pump, recheck BG in 1 hr. If BG has not decreased, give correction bolus by syringe and have student change infusion set/site if supplies are available or call parent.

→ Check BG and ketones every 2 hrs and give correction dose until BG reaches target range and ketones clear, by syringe until site is changed.

*If taking Regular, NPH or NPH mix insulin, call parent for direction.

Low blood glucose (hypoglycemia)

Some symptoms of low BG:

→ Sweating	→ Hunger
→ Headache	→ Dizziness
→ Drowsiness	→ Confusion
→ Trembling	→ Palpitations
→ Blurred vision	→ Speech Impairment

Hypoglycemia protocol: the rule of 15

If blood glucose is less than 70 mg/dl or symptomatic (70 to 100 mg/dl)

→ Eat/drink 15 grams of carbohydrate

→ Check BG again in 15 minutes; if not above 70 mg/dl repeat treatment

→ Check BG again in 15 minutes; if not above 70mg/dl repeat treatment and contact parent.

These items have 15 grams of carbohydrate:

- 3 Glucose tablets → 4 oz of juice or soda (not diet)
- 6-7 hard candies such as lifesavers
- 1 tablespoon of table sugar or honey

Rx:

Glucagon: If child becomes unconscious, unable to cooperate, or has a seizure, give glucagon 0.5/1.0 mg subcutaneously. (Please circle dose) Call 911 and parents. Do not force eating or drinking. Turn on side.

I hereby certify that the above information is complete and I have provided the school with all information that they will need to reasonably care for and monitor my child's health related to his/her diabetes. I give permission for the school to talk to my doctor, nurse practitioner, and/or physician's assistant and/or nurse.

Above I hereby certify that my child can monitor and manage his/her care without supervision from school staff except in emergencies.

Signature and dates: Parents _____ Student _____ Date _____

Physician _____ Date _____ School Representative and Title _____ 5/08