

Demographics				
Student Name:	DOB:	Grade:	Diagnosis:	
Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:	
Insulin Orders				
Insulin Dosing: ☐ Carbohydrate coverage ☐ Correction dose only ☐ Correction dose plus CHO coverage ☐ Fixed dose ☐ Fixed dose with correction scale ☐ See attached dosing scale				
Insulin(s): ☐ Rapid Acting: ☐ Apidra ☐ Humalog ☐ Novolog ☐ Admelog ☐ Other (specify): _____ ☐ Any of the rapid acting insulins may be substituted for the others				
☐ Long Acting (if given at school): _____ Give _____ unit(s) of insulin Sub-Q at _____ (time)				
Insulin Delivery: ☐ Pen ☐ Syringe ☐ Pump (make/model): _____				
Carbohydrate (CHO) Coverage per meal: ☐ _____ unit(s) of insulin Sub-Q per _____ grams of CHO at breakfast ☐ _____ unit(s) of insulin Sub-Q per _____ grams of CHO at lunch ☐ _____ unit(s) of insulin Sub-Q per _____ grams of CHO at dinner				
Carbohydrate Dose Adjustment Prior To Strenuous Exercise Within _____ Minutes: ☐ Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at breakfast ☐ Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at lunch ☐ Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at dinner				
Correction Dose: ☐ Give _____ unit(s) of insulin Sub-Q for every _____ mg/dl greater than BG of _____ mg/dl ☐ If pre-breakfast BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose ☐ If pre-lunch BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose ☐ If pre-dinner BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose				
☐ Fixed Dose Insulin: _____ unit(s) of insulin Sub-Q given before school meals ☐ Split Insulin Dose: Give _____ unit(s) or _____% of meal insulin dose Sub-Q before meal and _____ unit(s) or _____% of meal insulin dose Sub-Q after meal				
Snack Insulin Coverage: ☐ No snack coverage ☐ Snack coverage if BG > _____ mg/dl ☐ _____ unit(s) of insulin Sub-Q per _____ grams of CHO				
Insulin Dose Administration Principles				* See page 2 for Hyperglycemia management
Insulin should be given: ☐ Before meals ☐ Before snacks ☐ Other times (please specify): _____ ☐ For correction if BG > _____ mg/dl and _____ hours since last dose/bolus ☐ If CHO intake cannot be predetermined, insulin should be given no more than _____ minutes after start of meal/snack ☐ If parent/guardian requests, insulin should be given no more than _____ minutes after start of meal/snack ☐ Use pump or bolus device calculations per programmed settings, once settings have been verified ☐ Parent/Guardian has permission to increase/decrease insulin correction dose by +/- one (1) unit to three (3) units				
Independent Insulin Administration Skills & Supervision Needs*				*Skills to be verified by school nurse
☐ Insulin dose calculations ☐ Independent ☐ With Supervision	☐ Carbohydrate counting ☐ Independent ☐ With Supervision	☐ Measuring insulin ☐ Independent ☐ With Supervision	☐ Insulin administration ☐ Independent ☐ With Supervision	
Other Diabetes Medication				
Name of Medication	Time	Dosage	Route	Possible Side Effects
Authorizations				
HEALTH CARE PROVIDER AUTHORIZATION I authorize the administration of the medications and student diabetes self-management as ordered above. Provider Name (PRINT): _____ Phone: _____ Fax: _____ Provider Signature: _____ Date: _____			PARENT/GUARDIAN AUTHORIZATION By signing below, I authorize: • The designated school personnel to administer the medication and treatment orders as prescribed above. By signing below, I agree to: • Provide the necessary diabetes management supplies and equipment; and • Notify the nurse of any changes in my child's care or condition. Parent/Guardian Signature: _____ Date: _____	
Acknowledged and received by: _____			School Nurse: _____ Date: _____	

Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ____/____/____ to End ____/____/____ or for School Year _____

Student Name: _____		DOB: _____	
Blood Glucose Monitoring*		*Self-management skills to be verified by school nurse	
Blood Glucose (BG) Monitoring: ☐ Before meals ☐ Before PE/Activity ☐ After PE/Activity ☐ Prior to dismissal ☐ Additional monitoring per parent/guardian request ☐ For symptoms of hypo/hyperglycemia & anytime the student does not feel well ☐ Student may independently check BG*			
Continuous Glucose Monitoring			
☐ Uses CGM Make/Model: _____ Alarms set for: Low ____ mg/dl High ____ mg/dl ☐ If sensor falls out at school, notify parent/guardian			
Hypoglycemia Management*		*Self-management skills to be verified by school nurse	
Mild or Moderate Hypoglycemia (BG below ____ mg/dl) ☐ Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious & able to swallow. ☐ Suspend pump for BG < ____ mg/dl and restart pump when BG > ____ mg/dl ☐ Student should consume a meal or snack within ____ minutes after treating hypoglycemia ☐ Other: _____ Always treat hypoglycemia before the administration of meal/snack insulin Repeat BG check 15 minutes after use of quick-acting glucose - If BG still low, re-treat with 15 grams quick-acting CHO as stated above - If BG in acceptable range and it is lunch or snack time, have student eat and cover meal CHO per orders - If CGM in use and BG ≥70 mg/dL and arrow going up, no need to recheck Student may self-manage mild or moderate hypoglycemia and notify the school nurse*: ☐ Yes ☐ No			
Severe Hypoglycemia (includes any of the following symptoms): - Unconsciousness - Semi-consciousness - Inability to control airway - Inability to swallow - Seizing - Worsening of symptoms despite treatment/retreatment as above ☐ GLUCAGON injection: ☐ 1 mg ☐ 0.5 mg IM or Sub-Q - Place student in the recovery position - Suspend pump, if applicable, and restart pump at BG > ____ mg/dl - Call 911 and state glucagon was given for hypoglycemia; notify parent/guardian ☐ If glucagon is not available or there is no response to glucagon, administer glucose gel inside cheek, even if unconscious or seizing. If glucose gel is administered, place student in recovery position.			
Hyperglycemia Management*		*Self-management skills to be verified by school nurse	
If BG greater than ____ mg/dl, or when child complains of nausea, vomiting, and/or abdominal pain, check urine/blood for ketones. If urine ketones are trace to small or blood ketones ____ mmol/L: - Give ____ ounces of sugar-free fluid or water per hour as tolerated - Give insulin as listed in insulin orders no more than every ____ hour(s) If urine ketones are moderate to large or blood ketones greater than ____ mmol/L - Give ____ ounces of sugar-free fluid or water per hour as tolerated - If student uses pump, disconnect pump - Give insulin as listed in insulin orders no more than every ____ hour(s) by injection If large ketones and vomiting or large ketones and other signs of ketoacidosis, call 911. Notify parent/guardian. Recheck BG and ketones ____ hours after administering insulin Contact parent/guardian for: ☐ BG > ____ mg/dl ☐ Ketones ____ mmol/L Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse*: ☐ Yes ☐ No			
Ketone Coverage			
For ketones trace to small (urine)/< ____ mmol/L (blood) ☐ Correction dose plus ____ unit(s) of insulin ☐ ____ unit(s) of insulin		For ketones moderate to large (urine)/> ____ mmol/L (blood) ☐ Correction dose plus ____ unit(s) of insulin ☐ ____ unit(s) of insulin	
Parent/Guardian Name: _____		Signature: _____	
Provider Name: _____		Date: _____	

Acknowledged and received by: _____	School Nurse: _____	Date: _____
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Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ____/____/____ to End ____/____/____ or for School Year _____

Student Name: _____		DOB: _____	
Physical Education, Physical Activity, and Sports			
Self-management skills to be verified by school nurse ☐ Avoid physical education/physical activity/sports if: ☐ BG < ____ mg/dl ☐ BG > ____ mg/dl ☐ Trace/small ketones present ☐ Moderate/large ketones present ☐ If BG is ≤ ____ mg/dl, give 15 grams of CHO and return to physical education/physical activity/sports ☐ May disconnect pump for physical education/physical activity/ sports ☐ Student may set temporary basal rate for physical education/physical activity/sports ☐ Other: _____			
Transportation			
Self-management skills to be verified by school nurse ☐ Check BG prior to dismissal ☐ If BG is not > ____ mg/dl, give ____ grams carbohydrate snack ☐ BG must be > ____ mg/dl for bus ride/walk home ☐ Only check BG if symptomatic prior to bus ride/walk home ☐ Allow student to carry quick-acting glucose for consumption on bus, as needed for hypoglycemia ☐ Student must be transported home with parent/guardian if (specify): _____ ☐ Other: _____			
Disaster Plan (if needed for lockdown, 72 hr shelter in place)			
☐ Continue to follow orders contained in this medical management plan ☐ Additional insulin orders as follows: _____ ☐ Other: _____			
Pump Management			
Type of Pump: _____ Pump start date: _____ Child Lock: ☐ On ☐ Off Basal rates: _____ unit(s)/hour _____ AM/PM _____ unit(s)/hour _____ AM/PM _____ unit(s)/hour _____ AM/PM _____ unit(s)/hour _____ AM/PM _____ unit(s)/hour _____ AM/PM _____ unit(s)/hour _____ AM/PM Additional Hyperglycemia Management: ☐ If BG > ____ mg/dl and has not decreased over ____ hours after bolus, consider infusion site change. Notify parent/guardian ☐ For infusion site failure: ☐ Give insulin via syringe or pen ☐ Change infusion site ☐ For suspected pump failure, suspend or remove pump and give insulin via syringe or pen ☐ If BG > ____ mg/dl and <u>moderate to large</u> ketones, student should change infusion site and give correction dose by pen or syringe ☐ Comments: _____			
Independent Pump Management Skills and Supervision Needs*			
*Skills to be verified by school nurse. Supervision will be provided if not fully independent when appropriate Student is independent in the pump skills indicated below: ☐ Carbohydrate counting ☐ Bolus an insulin dose ☐ Set a basal rate/temporary basal rate ☐ Reconnect pump at infusion set ☐ Prepare and insert infusion set ☐ Troubleshoot alarms and malfunctions ☐ Give self-injection if needed ☐ Disconnect pump ☐ Other: _____			
Additional Orders			
☐ Please FAX copies of BG/insulin diabetes management records every ____ weeks (FAX number: _____) ☐ Other orders: _____			
Parent/Guardian Consent for Self-Management			
☐ I acknowledge that my child ☐ is ☐ is not authorized to self-manage as indicated by my child's health care provider. <i>I understand the school nurse will work with my child to learn self-management skills he/she is not currently capable of or authorized to perform independently.</i> My child has my permission to independently perform the diabetes tasks listed below as indicated by my child's health care provider: ☐ Blood glucose monitoring ☐ Insulin administration ☐ Pump management ☐ Carbohydrate counting ☐ Insulin dose calculation ☐ Other: _____			
Parent/Guardian Name: _____		Signature: _____	
Provider Name: _____		Signature: _____	
Date: _____		Date: _____	
Acknowledged and received by: _____		School Nurse: _____	
Date: _____		Date: _____	

This order is valid for one year from the date of prescriber's signature below.

School: Garrison Forest School

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed annually, for each medication, or when there is a change in dosage or time of administration of a medication.

- * Prescription medication must be in a container labeled by the pharmacist or prescriber.
- * Non-prescription medication must be in the original container with the label intact.
- * An adult must bring the medication to the school.
- * The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____

(Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____

(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____

Signature

Date

School RN approval for self carry/self administration of emergency medication: _____

Signature

Date

Order reviewed by the school RN: _____

Signature

Date