MUSC Pediatric Endocrinology and Diabetes Insulin Management Orders

Student:_____ **Date of Birth:**_____
School:_____ **County:**_____ **Fax Number:**_____
Diagnosis: ( ) Type 1 Diabetes ( ) Type 2 Diabetes ( ) MODY ( ) Other :_____

Task	By Nurse	With Nurse Supervision	Independent: Nurse does not need to monitor student	Independent: Nurse to monitor student ___times per week
Blood glucose monitoring				
Carb counting				
Calculating insulin dose				
Drawing up insulin				
Administering insulin				
Changing pump site				

( ) Student may self-carry all supplies in school, on school bus, for extracurricular activities, and school trips.

( ) Student may be independent for conscious hypoglycemia and carry supplies for treatment of conscious hypoglycemia.

( ) Student able to self manage and parents agree for school field trips

Monitor Blood Glucose:

- Monitor before meals, physical activity, and dismissal
- Monitor for symptoms of hyper/hypoglycemia
- **Allow use of CGM readings** if between 70–300 mg/dL and consistent with symptoms **(if approved by district)**

** If two periods of physical activity are less than 1 hour apart, blood sugar may be checked once before the first activity. Continue to watch for symptoms of low blood sugar and treat as needed.**

Perform finger stick if:

- CGM still reads <70 mg/dl 15 minutes after treatment
- CGM reading is unavailable or changing rapidly
- CGM lacks both number and trend arrow
- Suspected CGM failure

Low Blood Glucose (<70 mg/dL):

- Give 15g carbs (4 oz juice, 1 pack gel, 4 glucose tablets). Recheck in 15 minutes (finger stick). Repeat if still <70 mg/dL.
- **For UNCONSCIOUS HYPOGLYCEMIA or SEIZURE:** Give _____mg Glucagon IM, **or** 3mg nasal Baqsimi, **or** Gvoke (0.5mg for ages 2–11, 1mg for 12+), **or** Zegalogue 0.6mg SQ. Turn student on their side and **call 911**. (All Glucagon forms are interchangeable and approved for school use.)
- **If on insulin pump and severe low BG occurs**, stop insulin by suspending the pump OR disconnecting it from the body. **Always send the pump with EMS to the hospital.**

High Blood Glucose Orders:

- **Before Meals:** Give correction insulin before eating – follow correction/sliding scale on page 2.
- **INJECTIONS:** Sliding Scale/Correction Factor: Should not be given more frequently than every 3 hrs from last insulin dose.
- **INSULIN PUMP:** Use pump-calculated correction; cannot be given more frequently than every 2 hrs from last dose.
  - For BG >300 mg/dL that has not decreased in 2 hrs after correction, consider pump failure. Call parents and give insulin **by injection only**. Repeat corrections every 3 hrs and continue to give insulin for carb coverage with meals/snacks.

KETONES: Check urine/blood ketones if BG >240 for >3 hours on CGM or after two consecutive readings >240 on glucometer.

- For moderate to large ketones, add _____unit(s) to correction and give extra water to drink.
- Even with positive ketones, the child should remain at school if clinically well (i.e. not vomiting, able to concentrate). **If ketones are moderate to large with vomiting, give correction before sending home with parent.**
- **Pump + Ketones:** Use pump to calculate correction but give via **injection only**. Alert parents to **change site.**
- **CALL EMS FOR SHORTNESS OF BREATH (KUSSMAUL BREATHING) AND LETHARGY.**

PE/Exercise and Before School Dismissal:

- **BG <70 mg/dL:** Treat per low BG protocol. May participate in PE or be dismissed from school when **BG >100 mg/dL**.
- **BG 70–100 mg/dL:** Give **15g uncovered snack**. May immediately participate in PE or be dismissed from school.
- **BG >240 mg/dL with moderate/large ketones: No exercise**. Refer to high BG orders.

Administer short-acting insulin (Novolog, Humalog, Admelog, Apidra, or Fiasp) per prescribed ratio below. All insulin brands/generics are interchangeable for school use. Confirm insulin is short-acting, not long-acting.

Rounding Rules Injections: **Whole unit** (round down 0.1-0.4, round up 0.5-0.9) **Half unit** (Round down 0.1-0.3, round to half unit 0.4-0.6, round up 0.7-0.9)

Insulin Injections

BREAKFAST: Insulin/Carbohydrate ratio 1 unit for every _____grams of carbohydrates
LUNCH: Insulin/Carbohydrate ratio 1 unit for every _____grams of carbohydrates
SNACK: Insulin/Carbohydrate ratio 1 unit for every _____grams of carbohydrates

****Snack Insulin Guidelines:** If student on injections and it's been **≥3 hours** since the last insulin dose: give **carb coverage and correction PRN for high blood sugar**. If it's been **<3 hours**: give **carb coverage only (no correction)****

Correction Factor **OR** **Sliding Scale**

$$\text{Correction Dose} = \frac{\text{Current Blood Glucose} - \text{Target Glucose}}{\text{Correction Factor}}$$

Target Glucose: _____
Correction Factor: _____

Blood Glucose >120, give _____units
Blood Glucose >150, give _____units
Blood Glucose >200, give _____units
Blood Glucose >250, give _____units
Blood Glucose >300, give _____units
Blood Glucose >350, give _____units

Insulin Pump

- **Follow pump instructions. School may confirm model of insulin pump with parent/caregiver**
- **In case of pump failure or if the student switches back to injections, follow injection orders above**
- **May utilize pump activity/exercise feature for student during physical activity if parents/guardians request/consent**

Insulin Pump Settings:

Time	Carbohydrate Ratio	Correction Factor	Target Glucose

**** If using a CGM or pump, the student's diabetes devices and cell phone MUST stay near the student to deliver insulin and monitor blood glucose. Wi-Fi and Bluetooth may be needed for proper function of prescribed diabetes device****

Additional notes:

Completed By: **Printed Name:**_____ **Signature**_____

Authorized By:

_____ _____ _____
Printed Name of Legal Prescriber **Signature of Legal Prescriber** **Date**

I give permission for my child to receive the above medication/procedure as directed. I understand that the school nurse and my child's diabetes team may exchange my child's health information in order to meet my child's care needs at school.

_____ _____ _____
Signature of Parent/Legal Guardian **Date** **Phone Number of Parent/Legal Guardian**

_____ _____ _____
School Nurse (print name and title) **Signature of School Nurse** **Date**

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