Horry County Schools

New medical orders must be provided at the beginning of each school year dated after July 1st

Diabetic Prescribed Plan of Care Order Set

(The Prescribing Health Care Provider must complete page 1 and 2 of this order set)

Name: _____ **Date of Birth:** _____ **School Year:** _____

***Diagnosis*:** ☐ **Type I Diabetes** ☐ **Type II Diabetes** ☐ **Hyperglycemia-Insulin Resistance** ☐ **Hypoglycemia**

***Diet*:** ☐ **Diet:** _____ **may attach additional information**

☐ **Snacks (parent to provide) to be given:** ☐ time: _____ ☐ Before P.E. ☐ Before Bus Ride Home

***Exercise*:** ☐ **Unrestricted** ☐ **Restricted (specify):** _____

***Allow*:** ☐ **Unrestricted restroom privileges** ☐ **Water Bottle in Classroom**

***Blood Glucose Monitoring*:** **Please **check** appropriate requirements*

1. **This child's target blood glucose range is:** ☐ **100-200 (age 0-5 years)** ☐ **80 – 180 (age 6-12 years)**
   ☐ **80 – 150 (age 13+ years)** ☐ **70 – 140 (non-diabetic)**
   ☐ **Other range:** _____ **to** _____.
2. **This student needs assistance to perform blood glucose testing:** ☐ **Yes** ☐ **No**
3. **Blood glucose monitor & equipment should be kept:** ☐ **with child** ☐ **nurse's office** ☐ **classroom with teacher**
4. **Blood glucose monitoring to be done:** ☐ **Before Lunch** ☐ **Before Snack**
   ☐ **Before P.E.** ☐ **As needed to determine hypo / hyperglycemia**
   ☐ **Before Bus home** ☐ **Other (specify):** _____

***Insulin Requirements*:** **Please **check** appropriate requirements and **circle** the **prescribed insulin**.*

1. **The child can administer his/her own insulin:** ☐ Yes, unsupervised ☐ Yes, supervised ☐ No
2. **Insulin is required on a daily basis at meals and snack times:** ☐ Yes ☐ No

☐ **Novolog / Humalog / Apidra / Admelog via insulin pump using preprogrammed settings.**

☐ **Novolog / Humalog / Apidra / Admelog:** _____ **units per** _____ **grams carbohydrate + [BG -** _____**] /** _____

☐ **Novolog / Humalog / Apidra / Admelog / Regular for sliding scale correction:**

BG > 150, give _____ unit BG > 300, give _____ units
BG > 200, give _____ units BG > 350, give _____ units
BG > 250, give _____ units BG > 400, give _____ units

☐ **Other:** _____.

3. **Insulin is required for urine ketones:** ☐ **Yes** ☐ **No (Check Ketones if BG is >**_____ **)**

☐ **Novolog / Humalog / Apidra / Admelog / Regular:**
Small Ketones give _____ **units / Moderate Ketones give** _____ **units / Large Ketones give** _____ **units.**

☐ Give in addition to insulin coverage with meals ordered above.

☐ Give via injection ☐ Give via pump *(* May be given every 2-3 hours but only if blood glucose is > 240.)*

This order set consists of 2 pages; Please complete and sign both pages. Attach additional orders on separate sheet.

_____ _____ _____ / _____
Prescribing MD / APRN / PA Signature **Date** **Telephone No.** **Fax No.**

_____ _____
Printed Name of Prescriber **Office Address**

Note to parent/guardian: Signing this form shall release the School and staff from any liability that might result from this plan of action. I give permission for the school to contact the above prescriber if any questions regarding my child's treatment plan.

_____ _____ _____ _____
Parent / Guardian Signature **Printed Name of Parent / Guardian** **Date** **Telephone No.**

…It is the parent/guardian's responsibility to provide all medications, supplies, and snacks for the child to the school.

Horry County Schools

Diabetic Prescribed Plan of Care Order Set

(Prescribing Health Care Provider complete page 1 and 2 of this order set)

Name: _____ **Date of Birth:** _____ **School Year:** _____

HYPOGLYCEMIA Protocol (Low Blood Sugar)

Signs & Symptoms:

∗ hunger	∗ staring	∗becoming very quiet	∗ dizzy
∗ headache	∗ clammy sweat	∗ nervous	∗ unable to think clearly
∗ restless	∗ weak	∗ combative	∗ unusually sleepy
∗ pounding heart	* stumbling around	∗ blurry vision	∗ crying
∗ shaky	∗ pale	∗ confused/disoriented	∗ change in personality (irritable)

LOW BLOOD GLUCOSE FOR THIS CHILD REQUIRING INTERVENTION IS:

Blood Glucose (Less than) < _____ *(provide BG value here in the blank provided)*

1. **Give 15 grams of simple sugar**:
   - ½ cup (4 oz.) regular soft drink
   - ½ cup (4 oz.) juice
   - 3 – 4 glucose tablets
   - 15 skittles
   - 12 sweet tarts
   - 2 – 3 rolls of Smarties
   - 1 small tube of cake icing gel
   - 3 – 5 small sugar cubes
   - 2 – 3 packs of table sugar
2. Follow immediately with a **15 gram snack of complex carbohydrate or lunch**. Samples of a 15 gram complex carbohydrate snack are <u>one</u> of the following:
   - 4 peanut butter or cheese crackers
   - ½ sandwich
   - 1 small bag of pretzels, chips, etc.
3. If no improvement of symptoms within 15 minutes, give another simple sugar choice.
4. Recheck the blood glucose 30 minutes after initial treatment. Call parent if the blood glucose does not rise > 80.
5. Allow 30 – 60 minutes for a complete recovery before resuming normal school activity (tests, PE, class work)
6. **It is <u>not</u> necessary to send the student home once the blood glucose is above 80.**

HYPERGLYCEMIA Protocol (High Blood Sugar)

Signs & Symptoms:

∗ dry mouth ∗ increased urination ∗ headache ∗ sores or infections that will not heal
∗ thirst ∗ hungry ∗ tired ∗ sleepy ∗ dry, itchy skin

∗ **If symptoms persist --- can lead to nausea, vomiting, stomach pain, fruity smelling breath.**

HIGH BLOOD GLUCOSE FOR THIS CHILD REQUIRING INTERVENTION IS*:*

Blood Glucose (Greater than) > _____ *(provide BG value here in the blank provided)*

1. Encourage extra liquids without sugar such as water. No extra juice or milk.
2. Allow frequent trips to the restroom and checks for ketones if strips available.
3. Call parent if ketones present and treat with supplemental insulin if available and blood glucose is <u>≥</u>240.
4. If the blood glucose is > 300, do NOT participate in PE or sports – non-strenuous activity like walking is allowed.
5. Student does NOT need to be sent home unless vomiting, ketones, or other acute illness present.

EMERGENCY PLAN OF ACTION:

Have you prescribed *Glucagon* for this child? ☐ Yes ☐ No

FOR UNCONSCIOUS HYPOGLYCEMIA or SEIZURE: Give _____ mg Glucagon IM, or 3 mg nasal Baqsimi, or Gvoke 0.5 mg

1. If the student becomes unconscious or unresponsive, administer *Glucagon* as ordered, *if it is provided to the school by parent / guardian*.
2. Call EMS 911.
3. Notify school personnel trained in CPR to come and stay with student and initiate CPR if needed prior to EMS arrival.
4. Contact parent, guardian or emergency contact immediately.

Prescribing MD / APRN / PA Signature	**Printed Name of Prescriber**	**Date**
Parent / Guardian Signature	**Printed Name of Parent / Guardian**	**Date**
HCS School RN Signature	**Printed Name of School RN**	**Date**

∗∗∗It is the parent/guardian's responsibility to provide all medications, supplies, and snacks for the child to the school.