



HEALTH CARE PROVIDER ORDER FOR STUDENT WITH DIABETES

Student: _____ DOB: _____ School: _____ Grade: _____
Health Care Provider: _____ Provider Phone Line: _____
Educator: _____ Fax: _____

Please Check to Indicate Student's level of Self-Care Ability:

- ☐ Totally independent with Diabetes Management
☐ Requires supervision/assistance with Diabetes care at school from the School Nurse

Glucose Monitoring at School: ☐ CONTINUOUS GLUCOSE MONITORING (CGM) ☐ Blood Glucose Monitor

*If student has a CGM, finger sticks will be performed if: symptoms do not match the sensor reading, sensor reading is unavailable or tracing is inconsistent, or if sensor is still reading below 70 mg/dl 15 minutes following low treatment.

Monitoring will be done per health care plan and as follows: ☐ High or Low Glucose Symptoms ☐ Before Meals
☐ With Physical Complaints/Illness ☐ Before/After PE ☐ Before leaving school ☐ Other: _____

Insulin Order: _____ ICD Code: _____

☐ Insulin Pump: Brand/Model: _____ ☐ Automated Insulin Delivery (AID)

For student with an insulin pump: Insulin PRN as prompted by pump or per parent/guardian instruction for BG correction and treatment for carbohydrates.

AID: Insulin dosing is automated by device based on CGM readings. Do not manually override unless directed by parent/guardian.

Parent/Guardian may adjust settings remotely ☐ YES ☐ NO

☐ Insulin Syringe ☐ Insulin Pen ☐ Insulin Smart Pen

For student receiving injections via syringe or pen or in the event of a pump failure:

Carbohydrate Coverage:	Correction scale:
Breakfast: Give 1 unit for _____ grams of carbohydrate	BG Range: _____ Give _____ units
AM Snack: Give 1 unit for _____ grams of carbohydrate	BG Range: _____ Give _____ units
Lunch: Give 1 unit for _____ grams of carbohydrate	BG Range: _____ Give _____ units
PM Snack: Give 1 unit for _____ grams of carbohydrate	BG Range: _____ Give _____ units
	BG Range: _____ Give _____ units

OR

Correction Formula: (Do not give insulin correction dose more than once every 3 hours)

Give _____ units of insulin for every _____ mg/dl of blood glucose above target blood glucose of _____ mg/dl.

Parent/Guardian authorized to request the School Nurse increase/decrease insulin dose: ☐ YES ☐ NO

Further Instructions: _____

Glucagon:

In the event of a severe hypoglycemic reaction (seizure, unconscious): School Nurse or trained staff to administer Glucagon _____ mg(s) by: _____ Intranasal spray _____ Intramuscular injection into thigh (if supplied by parent/guardian). **Give nothing by mouth! CALL 911 AND PARENT.**

Ketone Testing:

-Ketone testing may be performed at school per parent/guardian or MD request if strips are supplied by parent/guardian.

-Instructions/parameters for ketone testing: _____

-If ketones present: call parent, provide water, and have student avoid exercise. It is recommended that the student be released from school when ketones are moderate/large or if symptoms of illness are present in order to be treated and monitored more closely by parent/guardian.

Signatures:

My signature below provides authorization for the above written orders and exchange of health information to assist the School Nurse in developing an Individual Health Plan. I understand that this order must be renewed yearly and updated as needed with any future changes.

Health Care Provider: _____ **Date:** _____

Parent/Guardian: _____ **Date:** _____



HEALTH CARE PROVIDER ORDER UPDATE FOR STUDENT WITH DIABETES

Student: _____ DOB: _____ School: _____ Grade: _____
Physician: _____ Health Care Plan Phone Line: _____
Educator: _____ Fax: _____

Effective Date:	Update to existing plan of care:

Healthcare Provider Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

Effective Date:	Update to existing plan of care:

Healthcare Provider Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

Effective Date:	Update to existing plan of care:

Healthcare Provider Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

Effective Date:	Update to existing plan of care:

Healthcare Provider Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____