

SCHOOL DIABETES MEDICATION ORDERS (Pump)

Licensed Healthcare Provider (LHP) to Complete Annually

(Pump Name)

Student Photo Here

NAME: _____ DOB: _____ SCHOOL: _____ GRADE: _____

Start date: _____ End date: (not to exceed current school year) Last day of school Other: _____

LOW BLOOD GLUCOSE (BG) MANAGEMENT

- If BG is below 70, give _____ grams fast-acting carbohydrate (ie. 4 glucose tabs, 4 oz juice, 1 tube of glucose gel, etc.).
- Recheck BG in 15 minutes and repeat carbohydrate treatment if BG still < 80 or if child continues to be symptomatic.
School nurse to notify provider's office of repeated hypoglycemia trends (i.e. more than 2-3 lows per week).
- Once BG is > 80, may follow with 10-15 gram carb snack, or meal if time.

If unconscious or unresponsive, difficulty swallowing, or evidence of seizure: **Phone 911 immediately.** Do NOT give anything by mouth. If nurse or trained PDA is available, may administer Glucagon (_____ mg SQ or IM)

HIGH BLOOD GLUCOSE (BG) MANAGEMENT

Pump malfunction can cause severe hyperglycemia and ketosis. Student should check tubing and site if concerned.

- Correction with Insulin
 If BG is over target range (_____) for _____ hours after last bolus or carbohydrate intake, student should receive correction bolus of insulin per insulin administration orders
 Never correct for high blood sugars other than at mealtime, unless consultation with student's LHP (Licensed Healthcare Provider)
- Ketones: Test urine ketones if BG > 300 X 2, or Never. Call parent if child is having moderate or large ketones.
- No exercise with positive ketones or BG > than _____.
- Encourage student to drink plenty of water and provide rest if needed.

BLOOD GLUCOSE TESTING

BG to be tested: Before meals and for symptoms of low or high BG, or as set up by the 504 plan

Extra BG testing: before exercise, before PE, before going home, other: _____

Blood sugar at which parents should be notified: Low _____ mg/dL or High _____ mg/dL

Notify the parents if repeated hypoglycemia, abdominal pain, nausea/vomiting, fever, if hypoglycemic before going home, or if there is a refusal of care by the child.

INSULIN ADMINISTRATION at Mealtime Apidra® Humalog® Novolog® Other: _____

Insulin to Carb Ratio: _____ unit per _____ grams Carb

BG Correction Factor: _____ unit per _____ mg/dL > _____

Basal Rates (School Hours): _____

Parent/caregiver authorized to adjust insulin for carbs, BG level, or anticipated activity

Licensed medical personnel authorized to adjust the insulin dose by +/- 0 to 2 units after consultation with parent/caregiver

Pre-meal BG target: 70-150, or _____

Insulin dosing to be given: before meal or after meal

Insulin & syringe may be used during pump malfunction

after meal dosing when before meal BG < _____

STUDENT'S SELF-CARE *Healthcare Provider to Initial Ability Level*

- | | |
|---|--|
| 1. Totally independent management _____ | 6. Student administers insulin bolus independently or _____ |
| 2. Student tests independently or _____ | Student consults with nurse/parent/PDA for insulin dose _____ |
| Student needs verification of number by staff or _____ | Student self-boluses with verification of the number or _____ |
| Assist/Testing to be done by school nurse/PDA/parent _____ | Student self-boluses with nurse supervision or _____ |
| 3. Student counts carbohydrates independently or _____ | Boluses to be done by school nurse/PDA/parent _____ |
| Student consults with nurse/parent/PDA for carbohydrate count _____ | 7. Student needs assistance with infusion site change, pump programming, and pump troubling shooting by nurse/PDA/Parent _____ |
| 4. Student self treats mild hypoglycemia _____ | |
| 5. Student tests and interprets own ketones or _____ | |
| Student needs assistance with interpreting ketones _____ | |

DISASTER PLAN & ORDERS

Parent is responsible for providing and maintaining "disaster kit" and to notify school nurse. In case of disaster:

Use above BG correction scale + carb ratio coverage for disaster insulin dosing every 3-4 hrs

If Lantus or Levemir long-acting insulin is available, may administer 80% of their usual dose (_____)

If long-acting insulin is not available, then administer rapid-acting insulin every 3-4 hrs as indicated by BG levels.

LHP Signature: _____ Print Name: _____ Date: _____

Parent Signature: _____ Print Name: _____ Date: _____

School Nurse Signature: _____ Print Name: _____ Date: _____

CONTACT INFORMATION

Student: _____

Parent or Guardian to Complete Annually

EMERGENCY CONTACTS:

Mother/Guardian	Father/Guardian
Name:	Name:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Other:	Other:

ADDITIONAL EMERGENCY CONTACTS:		
1.	Relationship:	Phone:
2.	Relationship:	Phone:

LICENSED HEALTHCARE PROVIDER:		
Name:	Phone:	Fax:
Location/Address:		

DIABETES INFORMATION AND ACCOMMODATIONS

Parent/Guardian, School Nurse, and/or 504 Team to Complete Annually Together

Level of Independence: _____

DAILY DIABETES ROUTINES:

Daily Snacks (time): _____

Recess Times: _____

Blood Glucose testing: Time: _____
Location: _____

Insulin Injections: Time: _____
Location: _____

Breakfast eaten at (time): _____

PE days/times: _____

Lunch eaten at (time): _____

CLASSROOM CONSIDERATIONS:

When the student experiences either a high blood glucose reaction or a low blood glucose reaction, his/her thought processes are likely to be adversely affected. Therefore, accommodations will need to be made with regards to performance expectations during the time immediately before and for at least one hour after the episode is treated.

- **The classroom teacher will be informed** if the student has a blood glucose reading that could affect his/her functioning, i.e., blood glucose less than 80 or over 250 by: Student verbally Written note from the office Other (specify) _____
- **Field Trips:** All diabetes supplies are taken and care is provided by: Accompanying parent According to field trip procedure/diabetes care plan re: low/high blood glucose Other _____
- **Class Parties:** Food treats will be handled as follows: Student will eat treat Replace with parent supplied alternative Modify the treat _____ Schedule extra insulin per prearranged plan Call Parent

OTHER CONSIDERATIONS:

- **Transportation:** Does your child: Take the bus (Bus # _____) Walk Picked up by parent
- **Parent Designated Adult:** Is a PDA present for your child? Yes No (If Yes, PDA Documentation Required)
- **Extracurricular school activities:** List _____ Parents are responsible to alert other school programs that their child has a health condition and/or a care plan in place. Such programs may include, express child care, after school activities, etc.

EXTRA SUPPLIES STORED (including disaster supplies):

1.
2.
3.
4.

SIGNATURES:

Parent:	Date:
School Nurse:	Date: