HEALTHCARE PROVIDER ORDER & CARE PLAN FOR STUDENT WITH DIABETES (1 of 2)

TO BE FILLED OUT BY PARENT/GUARDIAN:

Student:_____ DOB:_____ School:_____ Grade:_____

Type____ Diabetes/Year of Diagnosis:_____ This plan is only valid for the current school year:_____--_____

IF STUDENT IS SENT TO THE HEALTH ROOM THEY MUST BE ACCOMPANIED BY AN ESCORT.

HYPOGLYCEMIA: blood sugar less than 80mg/dl

Signs and symptoms of hypoglycemia:

- Dizziness
- Shaking
- Anxiety
- Hunger
- Blurry vision
- Weakness/fatigue
- Headache
- Behavior changes
- Pallor
- Loss of consciousness
- Seizure

1. Check blood sugar. If meter is not available and child has any of the above symptoms, proceed to step 2.
2. If blood sugar less than 80 mg/dl: Treat with 15 grams of fast acting carbohydrate (4 oz juice, 6 oz regular soda, 3-4 glucose tablets, 3-4 pieces of hard candy, 3 tsp of sugar, _____).
   If unable to swallow safely, administer 1 tube of glucose gel to inside of cheek.
3. Recheck and retreat every 15 minutes until blood sugar greater than 80 mg/dl.
4. When blood sugar is above 80 mg/dl give a complex carbohydrate (crackers with cheese, granola bar, trail mix etc.), if it is going to be more than an hour until the next meal or snack.
5. If unable/unwilling to take fast acting carbohydrate, having seizures, or is unconscious:
   Administer Glucagon by trained staff, call 911, and contact parent/guardian.
   If student has an insulin pump, suspend or remove pump.

HYPERGLYCEMIA: blood sugar greater than 300mg/dl

Signs and symptoms of hyperglycemia

- Increased thirst
- Frequent urination
- Hunger
- Fatigue
- Irritability
- Double vision
- Nausea/Vomiting
- Abdominal pain

1. Check blood sugar.
2. If blood sugar is over 300 mg/dl and greater than 2 hrs since last insulin dose, give insulin per sliding scale or bolus via pump.
3. **Check ketones.** If ketones are present, call parents. **STUDENT SHOULD NOT EXERCISE.**
4. Give 8-16 oz. of water per hr.
5. Recheck blood sugar in 2 hrs and treat with sliding scale insulin, as needed. **** See below for pump.***
6. When having symptoms of nausea and vomiting student will be released from school to parent/guardian.

*** When student has insulin pump:**

Blood sugar greater than 300 mg/dl with ketones or 2 consecutive unexplained blood sugars greater than 300 mg/dl (with or without ketones), may indicate a malfunction in the pump. Student may require insulin via injection and/or new infusion site. **PARENTS MUST BE NOTIFIED.**

SIGNATURES

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse.

I authorize the Diabetes Care Team to notify me/leave message via:

☐ Voice mail ☐ Text ☐ E-mail: _____ Cell Phone_____

Parent _____ Date _____ Alternate Phone_____

School Health Nurse Review: _____Date: _____

HEALTHCARE PROVIDER ORDER & CARE PLAN FOR STUDENT WITH DIABETES (2 of 2)

FOR LICENSED HEALTHCARE PROFESSIONAL USE ONLY:

Student:_____ DOB:_____ School:_____ Grade:_____

Type____ Diabetes/Year of Diagnosis:_____ This plan is only valid for the current school year:_____--_____

Trained School Diabetes Care Providers: _____, _____

Test Blood Sugar: ☐ Before lunch ☐ 2 hours after lunch ☐ Before exercise ☐ After exercise ☐ Before snack ☐ Before getting on bus ☐ As needed for signs/symptoms of low or high blood sugar

INSULIN ADMINISTRATION

Route: ☐ Pen ☐ Injection ☐ Pump – Type: _____

☐ If pump failure, use sliding scale

GLUCAGON ADMINISTRATION

☐ .5 mg (less than 10 years)

☐ 1.0 mg (more than 10 years)

Insulin type: ☐ Lantus: _____units daily at_____

Insulin type: For Sliding Scale insulin dosage and blood sugar correction. ONLY to be used every 2 hours.

☐ Humalog ☐ Novolog ☐ Apidra

☐ Parent/guardian authorized to increase/decrease sliding scale within the following range: +/- 2 units of insulin.

☐ If blood sugar greater than 300 mg/dl, check ketones.

Blood Sugar Range _____ mg/dl Administer _____ units
Blood Sugar Range _____mg/dl Administer _____ units
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Blood Sugar Range _____mg/dl Administer _____ units
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INSULIN/CARBOHYDRATE RATIO

- Breakfast: **1** unit of insulin per _____ grams of carbohydrate
- Mid Morning Snack: **1** unit of insulin per _____ grams of carbohydrate
- Lunch: **1** unit of insulin per _____ grams of carbohydrate
- Afternoon Snack: **1** unit of insulin per _____ grams of carbohydrate

☐ Parent/guardian authorized to increase or decrease insulin to carbohydrate ratio within the following range: 1 unit per prescribed grams of carbohydrates +/- 5 grams of carbohydrates.

STUDENT'S SELF CARE

Totally independent management.	☐ Yes ☐ No	Self injects with trained staff supervision.	☐ Yes ☐ No
Tests blood sugar independently.	☐ Yes ☐ No	Injections to be done by trained staff.	☐ Yes ☐ No
Tests and interprets urine/blood ketones.	☐ Yes ☐ No	Self treats mild hypoglycemia.	☐ Yes ☐ No
Needs verification of blood sugar by staff.	☐ Yes ☐ No	Monitors own snacks and meals.	☐ Yes ☐ No
Administers insulin independently.	☐ Yes ☐ No	Independently counts carbohydrates.	☐ Yes ☐ No
Self injects with verification of dose.	☐ Yes ☐ No		

SIGNATURES

Parent _____ Date_____

Physician _____ Date _____ Phone_____ Fax_____

School Health Nurse Review: _____ Date: _____