

## Health Care Provider Order for Student with Diabetes on Injections

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Diabetes Educator: \_\_\_\_\_ Phone: \_\_\_\_\_

**Monitor Blood Glucose**  As needed for signs/symptoms of low/high blood glucose and/or does not feel well  
 Before School Program  Before Snack  Mid-Morning  After School Program  
 Before Lunch  After lunch  Recess  Before PE  After PE  
 Extra-curricular activity  Behavioral Concern  2.5 Hours after Correction  
 School Dismissal  Before Riding Bus/Walking home  CGM alarms  Other: \_\_\_\_\_

**Target Ranges:**  < 5 y.o. 80-200 mg/dl  12-18 y.o. 70-150 mg/dl  
 5-11 y.o. 70-180 mg/dl  >18 y.o. 70-130 mg/dl OR \_\_\_\_\_ mg/dl to \_\_\_\_\_ mg/dl

**Notification to Parents: Low** < target range and **High** > 300 mg/dl or Other: \_\_\_\_\_ mg/dl to \_\_\_\_\_ mg/dl

Continuous glucose monitoring: Always *Confirm glucose level with a fingerstick/meter prior to treatment*

**Hypoglycemia:** Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here: \_\_\_\_\_

For severe symptoms: Administer Glucagon < 16 years old = 0.5 cc and > 16 years = 1.0 cc IM OR \_\_\_\_\_ mg(s) IM, **Call 911**

**Hyperglycemia:** Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here: \_\_\_\_\_

Ketone Testing *per Standards of Care for Diabetes Management in the School Setting – Colorado* OR Other: \_\_\_\_\_

**Blood Glucose Correction and Insulin Dosage Using (Rapid Acting/Short Acting) Insulin Type:** \_\_\_\_\_

Injection site:  Abdomen  Arm  Buttock  Other: \_\_\_\_\_ *Injections should be given subcutaneously & rotated*

To be given at:  Prior to lunch  Immediately after eating lunch  Split ½ before lunch & ½ after lunch  
 Other: \_\_\_\_\_

*If Correction dose is needed other than at time indicated, School Nurse will contact Health Care Provider for One-time order*

Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin *per Guidelines for Insulin Management\**

Blood Glucose Range \_\_\_\_\_ mg/dl Administer \_\_\_\_\_ units

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### Carbohydrates and Insulin Dosage:

Insulin to Carbohydrate Ratio: \_\_\_\_\_ unit(s) for every \_\_\_\_\_ grams of carbohydrate (or to be) eaten

Correction Factor: \_\_\_\_\_ unit of insulin for every \_\_\_\_\_ mg/dl in Blood glucose starting at \_\_\_\_\_.

Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

**Medication:** Follow *Guidelines for Insulin Administration by School Staff, Diabetes Resource Nurses February 2013*

Oral diabetes medication(s) Dose: \_\_\_\_\_ mg Times to be given: \_\_\_\_\_

NPH Insulin Dose: \_\_\_\_\_ units SQ Times to be given: \_\_\_\_\_

**Student's Self Care:**  No supervision  Full supervision,  Requires some supervision: ability level to be determined by school nurse and parent unless otherwise indicated here: \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

**SIGNATURES:** My signature below provides authorization for the above written orders and exchange of health information to assist the school nurse in developing an Individualized Health Plan. 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. This order is for a maximum of one year.

Physician: \_\_\_\_\_

Date: \_\_\_\_\_

Parent: \_\_\_\_\_

Date: \_\_\_\_\_

School Nurse: \_\_\_\_\_

Date: \_\_\_\_\_