******Emergency names and phone numbers are on computer health record******

Diabetes Orders

Student's Name _____ **DOB** _____
School _____
Physician _____ **Effective Date** _____
Physician Phone _____
Type of insulin: (circle one) Rapid or Short Acting: Apidra/Humalog/Novolog/Regular
Intermediate or Long-acting given at home: (cirlce one) NPH/Lantus/Levemir
Insulin to carbohydrate ratio (I:CR): _____ units/_____ grams or Fixed insulin lunch dose _____
Parent may adjust I:CR by +/- 1 to 5 grams Yes/No (circle one)
Correction Factor (CF) (insulin sensitivity): **CF: _____ units per _____ mg/dl over _____ mg/dl**
(Correction Factor Formula: Student's BG minus Target BG ÷ correction factor = insulin dose)

Usual Insulin Dose Range_____ **Target blood glucose range:** 70-110 pre-meal. **Other:** _____

Insulin Pump: (if applicable)
Type: _____
Basal Rates: Time: Rate (unitS per hr)
12:00 am = _____ _____
_____ _____
_____ _____
_____ _____

Blood Glucose Monitoring (in classroom if possible) or Location _____
Before am snack _____
Before lunch _____
Before exercise _____
After exercise _____
Signs of low or high blood sugar _____
Other _____

Child is able to:
(Circle all that apply)
Test own glucose
Determine insulin dose
Draw up insulin
Administer insulin dose
Manage/troubleshoot pump

Exercise and Sports
Student **should not** exercise if blood glucose is
Yes/No BG is below _____ mg/dl or
Yes/No above _____ mg/dl
Yes/No Snack before exercise Yes/No
Yes/No Snack after exercise Yes/No
Yes/No

Meals/ Snacks: _____
Breakfast _____
A.M. Snack _____
Lunch _____
P.M. Snack _____
Food in class, e.g. party _____

Supplies to be provided by parents: Blood Glucose Monitor and all monitoring supplies, Insulin and administration supplies, Glucagon emergency kit, snack foods, fast-acting glucose source, Ketone testing supplies, Insulin pump supplies if appropriate.

High blood glucose Management/Preventing Diabetic Ketoacidosis
If BG is above 250 mg/dl, wash hands and recheck. If still above 250:
→**If less than 2 hrs since last dose of Apidra, Humalog or Novolog, * recheck at 2 hrs after the last dose and continue as below.**
→**If 2 hrs or more since the last dose of Apidra, Humalog, or Novolog* give a correction dose using the correction factor formula.**
→Check urine for ketones. If positive, drink 6-8 oz liquid with no calories :every 30 minutes (e.g. water, diet soda)
→ **If moderate or large ketones at any time, call parent.**
→Check BG and ketones every 2 hrs and give correction dose until BG reaches target range and ketones clear.
→If BG and ketones are not decreasing after 4 hrs, call parent.
<u>Additional</u> Instructions for Insulin Pump Users:
→If ketones are negative, check pump and site. If okay, give correction) bolus by pump_
→If ketones are positive, give correction bolus by syringe <u>(not</u> by pump) and have student change infusion set/site if able or call parent.
→If initial correction bolus was given by pump, recheck BO in 1 hr. If BG has not decreased, give correction bolus by syringe and have student change infusion set/site if supplies are available or call parent.
→Check BG and ketones every 2 hrs and give correction dose until BG reaches target range and ketones clear, by syringe until site is changed.
If taking Regular, NPH or NPH mix insulin, call parent for direction.

Low blood glucose (hypoglycemia)
Some symptoms of low BO:
→Sweating..... →Hunger
→Headache..... →Dizziness
→Drowsiness..... →Confusion
→Trembling..... →Palpitations
→Blurred vision ..... →Speech Impairment

Hypoglycemia protocol: the rule of 15
If blood glucose is less than 70 mg/dl or symptomatic (70 to 100 mg/dl)
→Eat/drink 15 grams of carbohydrate
→Check BG again in 15 minutes; if not above 70 mg/dl repeat treatment
→Check BG again in 15 minutes; if not above 70mg/dl repeat treatment and contact parent.
These items have 15 grams of carbohydrate:
→ 3 Glucose tablets..... →4 oz of juice or soda (not diet)
→6-7 hard candies such as lifesavers
→1 tablespoon of table sugar or honey

Rx:
Glucagon: If child becomes unconscious, unable to cooperate, or has a seizure, give glucagon 0.5/1.0 mg subcutaneously. (Please circle dose) Call 911 and parents. Do not force eating or drinking. Turn on side.

☐ I hereby certify that the above information is complete and I have provided the school with all information that they will need to reasonably care for and monitor my child's health related to his/her diabetes. I give permission for the school to talk to my doctor, nurse practitioner, and/or physician's assistant and/or nurse.
☐ Above I hereby certify that my child can monitor and manage his/her care without supervision from school personnel except in emergencies
Signature and dates: Parents _____ Student _____ Date _____
Physician _____ Date _____ School Representative and Title _____

Diabetic Care Plan

Name _____ **DOB** _____ **Date** _____

To be completed by parent/guardian and the health care team. This document should be reviewed with necessary school staff and kept with the child's health records.

Emergency Information

Parent/Guardian	_____	Parent/Guardian	_____
Home phone	_____	Home phone	_____
Work phone	_____	Work phone	_____
Cell/pager	_____	Cell/pager	_____

Emergency Contacts

Name	_____	Name	_____
Relationship	_____	Relationship	_____
Home phone	_____	Home phone	_____
Work phone	_____	Work phone	_____
Cell phone	_____	Cell Phone	_____

Notify parent/guardian in the following situations _____

_____

Medical Alert yes_____ no_____ (please check)

Transportation Bus_____ Walk_____ Car_____ Bike_____ Other_____ (please check)

Hypoglycemia (low blood sugar)-please check the symptoms that apply to your child

- _____ irritability
- _____ hunger
- _____ shakiness
- _____ sleepiness
- _____ sweating
- _____ other symptoms (please describe) _____

At what time of day is the student most likely to have hypoglycemia?

_____

Hyperglycemia (high blood sugar) please check the symptoms that apply to your child

- _____ headache
- _____ hyperactivity
- _____ visual changes
- _____ thirst
- _____ changes in usual behavior
- _____ frequent urination
- _____ other symptoms (please describe) _____

Please add anything that you would like school personnel to know about your student's diabetic/health condition

_____

Parent/guardians must notify school nurse of changes in diabetic routine and/or medications and care plan will be updated to reflect changes.

Signature of parent/guardian_____ **Date**_____
Received by school nurse_____ **Date**_____
Updates_____