Maryland State Management of Diabetes at School/Order Form

This order is valid only for the Current School Year: _____(including summer session)

Student: _____ **DOB:** _____

School: _____ **Grade:** _____

CONTACT INFORMATION

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____

Other Emergency Contact: _____

Insulin Orders (complete only if insulin is needed at school):

1. Insulin administration via:

☐ Syringe and vial ☐ Insulin pen ☐ Insulin pump ☐ Other _____

☐ Insulin pump Type of pump: _____ Basal rates: _____

2. Insulin Before Lunch/Meals: Name of Insulin: _____

☐ Routine lunchtime dose: _____

☐ Per sliding scale as follows:

Meals

Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units
Blood Glucose	_____	to	_____	give _____ units

☐ Calculated insulin dose (**add** carbohydrate coverage and correction dose for total insulin dose):

Carbohydrate Coverage: Insulin to carbohydrate ratio

Give _____ # unit(s) insulin per _____ gms carbohydrate.

Correction:

Give _____ # unit(s) insulin per _____ mg/dl of glucose **above** _____ mg/dl

Subtract _____ # units for every _____ mg/dl of glucose **below** _____ mg/dl

☐ Insulin may be given after lunch if _____

3. Other times insulin may be given:

☐ Snack: Dose: _____ ☐ Calculated as above.

☐ Ketones: If ketones are _____ Give/Add: _____ unit(s)

If ketones are _____ Give/Add: _____ unit(s)

☐ Snack:

Blood Glucose Give:

_____ units

_____ units

_____ units

Health Care Provider Authorization for Management of Diabetes in School

My signature below provides authorization for the above written orders. This authorization is for a maximum of one school year. If changes are indicated, I will provide new written authorization, which may be faxed.

Health Care Provider Name: _____ **Signature:** _____ (original or stamped signature) ***Sign both sides.**

Address: _____ **City:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Date:** _____

Use for Prescriber's Address Stamp

Parent Consent for Management of Diabetes at School

I (We) request designated school personnel to administer the medication and treatment orders as prescribed above. I agree

1. To provide the necessary supplies and equipment
2. To notify the school nurse if there is a change in the student's diabetes management or health care provider.

I authorize the school nurse to communicate with the health care provider as necessary.

Parent/Guardian Signature _____ Date _____ ***Sign both sides.**

_____ Date _____

Order reviewed and signed by School Nurse (per local policy): Date:

Student: _____

Blood Glucose Monitoring:

Target range for blood glucose monitoring at school:_____

- ☐ Before snacks ☐ 2 hours or _____ hours after lunch
- ☐ Before meals ☐ 2 hours or _____ hours after a correction dose
- ☐ As needed for symptoms of hypo/hyperglycemia
- ☐ With signs and symptoms of illness
- ☐ Other times: _____

Hypoglycemia – blood glucose less than _____

☐ Self treatment for mild lows.

☐ Give _____ grams of fast-acting carbohydrate according to care plan. Recheck BG in 10-15 mins. Repeat treatment if BG less than ___mg/dl

☐ Provide extra protein & carbohydrate snack after treating low if next meal/snack greater than ____ minutes away

☐ Suspend pump for severe hypoglycemia for _____ mins.

If student is unconscious, having a seizure or unable to swallow, presume student is having a low blood sugar and:
Call 911, notify parent
☐ **Glucagon injection (1 mg in 1 cc) _____ mg, subcutaneously or intramuscular (IM)**
☐ **OK to use glucose gel inside cheek, even if unconscious, seizing.**
☐ **Other:** _____

Hyperglycemia – blood glucose greater than _____

☐ Check urine ketones, follow care plan, administer insulin as per orders. ☐ For pumps, insulin may be given by syringe or pen if needed.

☐ Encourage sugar free fluids, at least _____ ounces per _____.

☐ If student complains of nausea, vomiting or abdominal pain; check urine ketones & check insulin administration orders.

☐ Other: _____

* Transport to local Emergency Room may be needed with vomiting and large ketones.

Meal Plan

☐ AM snack, time: _____ ☐ PM snack time: _____ ☐ Avoid snack if blood glucose greater than _____ mg/dl.

☐ Lunch: _____

☐ Extra food allowed; ☐ Parent's discretion; ☐ Student's discretion

Exercise (check and/or complete all that apply)

Fast-acting carbohydrate source must be available before, during and after all exercise.

☐ With student ☐ With teacher

If most recent blood glucose is less than _____, exercise can occur when blood glucose is corrected and above _____.

☐ Eat _____ grams of carbohydrate ☐ Before ☐ Every 30 mins during ☐ After vigorous exercise

☐ Avoid exercise when blood glucose is greater than _____ or ketones are _____

Bus Transportation

☐ Blood glucose monitoring not required prior to boarding bus

☐ Check blood glucose 15 minutes prior to boarding bus

☐ Allow student to eat on bus if having symptoms of low blood glucose

☐ Provide care as follows: _____

Health Care Provider Assessment

Student can self-perform the following procedures (school nurse and parent must verify competency):

☐ Blood glucose monitoring ☐ Measuring insulin ☐ Injecting insulin ☐ Determining insulin dose

☐ Independently operating insulin pump

☐ Other: _____

Disaster Plan (if needed for lockdown, 24 hr shelter in place)**:**

☐ Follow insulin orders as on Management Form

☐ Additional insulin orders as follows: _____

☐ Administer long acting insulin as follows: _____

☐ Other: _____

Other instructions:

_____

Health Care Providers Signature:_____ Phone: _____ Date: _____

Parent's Signature: _____ Phone: _____ Date: _____

Order reviewed by School Nurse (per local policy): _____ Date:_____

Maryland State Supplemental Form for Students with Insulin Pumps

This order is valid only for the Current School Year:_____ (including summer session)

Student: _____ DOB: _____

School: _____ Grade: _____

CONTACT INFORMATION:

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell/pager: _____

Pump Resource Person: _____ Phone: _____

Other Emergency Contact: _____

Pump Management

Type of pump: _____ Start Date for Pump Therapy: _____

Type of Insulin in pump: _____

Basal rates: _____ 12am to _____ Comment: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Insulin/carbohydrate ratio: _____ Check Management of Diabetes at School Order or correction factor

Hyperglycemia:

____ Pump site should be changed if BG greater than _____ times _____

____ Insulin should be given by syringe or pen if needed _____

Management Skills of Student

- As verified by school nurse, health care provider and parent

	Independent?	
Count carbohydrates	__ yes	__ no
Calculate an insulin dose	__ yes	__ no
Bolus an insulin dose	__ yes	__ no
Reset basal rate profiles	__ yes	__ no
Set a temporary basal rate	__ yes	__ no
Disconnect pump	__ yes	__ no
Reconnect pump at infusion set	__ yes	__ no
Prepare infusion set for insertion	__ yes	__ no
Insert infusion set	__ yes	__ no
Troubleshoot alarms and malfunctions	__yes	__ no
Give self injection if needed	__ yes	__ no
Change batteries	__ yes	__ no

__ Student is non-independent Child Lock On? Yes No

Pump Supplies

Extra supplies needed include: Infusion sets, reservoir/cartridges, insertion device, insulin vial & syringes, batteries

Location of supplies: _____

Disaster Plan (If needed for lockdown, etc):

- ☐ Follow Insulin orders as on Management Form
- ☐ Insulin doses as follows: _____

Other: _____

Health Care Provider's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Order reviewed by School Nurse (per local policy): Date: _____