Health Care Provider Orders for Student with Diabetes on Injections/Oral Medication

To be completed by the Health Care Provider and used in conjunction with the Standards of Care for Diabetes Management in the School Setting – Colorado 2014

Student:	DOB:	School:	Grade:
Physician/Provider:			Phone:
Diabetes Educator:			Phone:

TARGET RANGE – Blood Glucose:	**mg/dl TO mg/dl**			
☐< 5y.o. 80-200mg/dl	☐ 5 – 8 y.o 80-200mg/dl	☐ 9-11y.o 70-180mg/dl	☐ 12-18y.o. 70-150mg/dl	☐ >18y.o. 70-130mg/dl
Notification to Parents: Low < *target range* and High > 300 mg/dl or ***Other:*** less than **mg/dl** and			greater than: **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:* Call 911 & Administer **Glucagon Dose:**	**mg**	**Intramuscular in ☐Arm ☐Buttocks ☐Thigh**
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:		

When to Check Blood Glucose: *For provision of student safety while limiting disruption to learning*

✔ **Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns**

☐ Before School Program ☐ Before Snack ☐ Mid-morning ☐ After School Program/Extracurricular Activity

☐ Before Lunch ☐ After Lunch ☐ Recess ☐ Before PE ☐ After PE

☐ School Dismissal ☐ Before riding bus/walking home ☐2.5 hrs after correction Other:

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

Injection site: ☐Abdomen ☐Arm ☐Buttock ☐Thigh *Injections should be given subcutaneously & rotated*

Lunchtime Correction: Give ☐ Prior to lunch ☐ Immediately after lunch ☐ Split ½ before lunch & ½ after lunch ☐ Other :

☐**Sensitivity/Correction Factor:** _____ unit insulin for every _____mg/dl above target BG range starting at _____mg/dl

Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones

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

When hyperglycemia occurs other than at lunchtime:

☐ If it has been greater than **3 hours** since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders **if approved by the school nurse and parent is notified.**

☐ **Cont**act Health Care Provider for One-time order

Carbohydrates and Insulin Dosage: ☐ **Breakfast** ☐**Snack** ☐**Lunch** ☐**Other:**

Insulin to Carbohydrate Ratio: _____**unit(s)** for every _____**grams** of carbohydrate to be eaten

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

☐ **Oral Medication:** _____ _____mg Time: _____

☐ **NPH Insulin** Dose: _____units SQ Time: _____

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 written orders above and exchange of health information to assist the school nurse 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: _____