

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

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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.

Snack:

Blood Glucose _____ Give: _____ units

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

_____ units

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

_____ 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:

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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: _____