Health Care Provider Order for Student with Diabetes on a Pump

Student Name:	Birth Date:
School:	Grade:
Physician:	Phone:
Diabetes Educator:	Phone:

Pump settings are set by the student's healthcare provider and should not be changed by the school staff.

Monitor Blood Glucose: ☐Before Lunch ☐After Lunch ☐Before P.E. ☐After P.E. ☐Before Snack
☐Before getting on bus/going home ☐As needed for signs/symptoms of low or high blood glucose

Target range for Blood Glucose: >_____ mg/dl to <_____ mg/dl

Notify parent if Blood Glucose values are: below _____ mg/dl or above _____ mg/dl

Hypoglycemia: Student should be accompanied to the Health Office if symptomatic or Blood Glucose <_____ mg/dl.

- ➢Check blood glucose – if blood glucose meter not available, treat symptoms.
- ➢Blood glucose below _____ mg/dl and/or symptomatic: Treat with 10 to 15 gram carbohydrate snack.
- ➢Mild symptoms: Treat with juice, glucose tabs, etc. until above _____ mg/dl, then protein snack or lunch.
- ➢Moderate symptoms if unable to drink juice: Administer glucose gel. Retreat until above _____ mg/dl, then protein snack or lunch.
- ➢Severe symptoms which may include seizures, unconscious, unable or unwilling to take gel or juice:
  Administer Glucagon®☐ _____ mgs IM or ☐ _____ Units SQ in insulin syringe if trained staff available and call 911.

Hyperglycemia:

- ☐Use pump calculation and correction bolus when blood glucose is above _____ mg/dl.
- ☐Check keytones if blood glucose is >_____mg/dl or with symptoms of illness/vomiting. If ketones present, call parent, provide water, and student should not exercise.
- ☐If blood glucose >_____ mg/dl with ketones or 2 consecutive unexplained blood glucose >_____ mg/dl (with or without ketones), i.e. malfunctioning pump. Student may require insulin via injection and/or new infusion set.
- ☐First contact parent then call healthcare provider for further instructions. May need insulin via syringe.
- ✓Student should be released from school when keytones are moderate/large, >0.6 mmol, or symptoms of illness to be treated and monitored more closely by parent.

Medications to be given:

☐Oral diabetes medication(s), Type _____	Dose _____	Times given _____
☐Insulin, Type _____	Times given _____	
☐ Glucagon®	Dose _____	Times given _____

Insulin to Carbohydrate ratio _____ units of insulin per _____ grams of carbohydrate

Carbohydrate ratio for snack: _____ units per _____ grams of carbs, _____ a.m. _____ p.m.
Bolus for carbohydrates should occur immediately: ☐Before eating ☐After eating ☐½ bolus before & ½ bolus after eating
☐Other: _____

Insulin dosing for High Blood Glucose

☐Blood glucose correction and insulin dosage **via syringe** is only to be administered when confirmed by school nurse, parent, or physician for treatment of hyperglycemia. Insulin Type:_____

Blood Glucose Range	Units Insulin
mg/dl	units
mg/dl	units
mg/dl	units
mg/dl	units
mg/dl	units

Student's Self Care: (ability level determined by school nurse and parent with input by physician)

- ☐Injection to be done by trained staff
- ☐Self injections with verification of dosage
- ☐Administers insulin independently
- ☐Independently monitors blood glucose
- ☐Independently counts carbohydrates
- ☐Self treats mild hypoglycemia
- ☐Tests and interprets urine/blood ketones
- ☐Needs assistance with pump management
- ☐Independently manages pump boluses
- ☐Self inserts new infusion set
- ☐Troubleshoots all alarms

Signatures:

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

Physician Signature:	**Date:**
Parent Signature:	**Date:**
District Nurse Signature:	**Date:**

Revised 3/2012