

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
www.coloradokidswithdiabetes.org

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

TARGET RANGE – Blood Glucose:	mg/dl	TO	mg/dl
<input type="checkbox"/> < 5y.o. 80-200mg/dl	<input type="checkbox"/> 5 – 8 y.o. 80-200mg/dl	<input type="checkbox"/> 9-11y.o. 70-180mg/dl	<input type="checkbox"/> 12-18y.o. 70-150mg/dl
Notification to Parents: Low < <u>target range</u> and High > 300 mg/dl or Other: less than <u> </u> mg/dl and greater than: <u> </u> mg/dl			
<input type="checkbox"/> Continuous glucose monitoring: Always Confirm glucose level with a fingerstick/meter prior to treatment unless student has a Dexcom G5 or G6, it may be used for dosing and treatment. Please follow Collaborative Guidelines for Dexcom G5 & G6: Therapeutic Dosing in the School Setting (www.coloradokidswithdiabetes.org)			

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: _____ 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

Check before meals and as mutually agreed upon by parent and school nurse

Other: _____

Injections should be given subcutaneously & rotated

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

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

Insulin Dosing Attached

<input type="checkbox"/> Sensitivity/Correction Factor:	_____ unit insulin for every _____ mg/dl above _____ starting at _____ mg/dl
Blood Glucose Range:	mg/dl to mg/dl Administer: units <input type="checkbox"/> Check ketones
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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.**

Contact Health Care Provider for One-time order

Carbohydrates and Insulin Dosage: Breakfast Snack Lunch Other:

(To be given in conjunction with the correction dose as indicated)

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

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: _____