

## Health Care Provider Order for Student with Diabetes on Insulin Pump

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Diabetes Educator: \_\_\_\_\_ Phone: \_\_\_\_\_

**Monitor Blood Glucose**  As needed for signs/symptoms of low/high blood glucose and/or does not feel well  
 Before School Program  Before Snack  Mid-Morning  After School Program  
 Before Lunch  After lunch  Recess  Before PE  After PE  
 Extra-curricular activity  Behavioral Concern  2.5 Hours after Correction  
 School Dismissal  Before Riding Bus/Walking home  CGM Alarm  Other: \_\_\_\_\_

**Target Ranges:**  < 5 y.o. 80-200 mg/dl  12-18 y.o. 70-150 mg/dl  
 5-11 y.o. 70-180 mg/dl  >18 y.o. 70-130 mg/dl OR \_\_\_\_\_ mg/dl to \_\_\_\_\_ mg/dl

**Notification to Parents:** Low < target range and High > 240mg/dl) or Other: \_\_\_\_\_ mg/dl to \_\_\_\_\_ 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: Administer Glucagon < 16 years old = 0.5 cc and > 16 years = 1.0 cc IM OR \_\_\_\_\_ mg(s) IM,  
*Disconnect Pump, Call 911*

**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: \_\_\_\_\_

**Insulin Pump:** Follow *Guidelines for Insulin Administration by School Staff, Diabetes Resource Nurses February 2013*

- Pump settings are established by the student's healthcare provider and should not be changed by the school staff. All setting changes to be made at home or by student providing self care as indicated on IHP.
- Internal safety features for the insulin pump should be active at all times while the student is at school - (Alarms set conservatively).

Insulin Pump Brand: \_\_\_\_\_ Type of Insulin in pump \_\_\_\_\_

**Sensitivity/Correction Factor:** \_\_\_\_\_ unit of insulin for every \_\_\_\_\_ mg/dl above the target blood glucose range

If blood glucose is less than \_\_\_\_\_ mg/dl, wait to give meal bolus until after meal

If blood glucose is greater than \_\_\_\_\_ mg/dl, deliver a correction bolus prior to eating

**Insulin to Carbohydrate ratio** \_\_\_\_\_ units of insulin per \_\_\_\_\_ grams of carbohydrate

Carbohydrate ratio for snack \_\_\_\_\_ units per \_\_\_\_\_ gm of carbs \_\_\_\_\_ am \_\_\_\_\_ pm

Bolus for carbohydrates should occur immediately  Before lunch  After lunch  ½ bolus before & ½ bolus after  
 Other: \_\_\_\_\_

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

**Pump Malfunctions: Disconnect pump when malfunctioning**

If pump is operational then the insulin dosing can be calculated by using the pump bolus calculator and then insulin given by injection

If pump is not operational:

Give insulin as indicated here: \_\_\_\_\_  Call Parent and Health Care Provider (for orders)

Give insulin according to Insulin to Carbohydrate Ratio and Correction Factor:  $Insulin\ Dose = [(Actual\ Blood\ Glucose - Target\ Range\ BG\ \_\_\_\_\_\_ (top\ of\ range) \div Insulin\ Sensitivity\ \_\_\_\_\_\_] + [\# \ carbohydrates\ consumed \div Insulin\ to\ Carb\ Ratio\ \_\_\_\_\_\_ units]$

**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 above written orders and exchange of health information to assist the school nurse in developing 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: \_\_\_\_\_