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

- < 5 y.o. 80-200mg/dl
- 5 - 8 y.o. 80-200mg/dl
- 9-11 y.o. 70-180mg/dl
- 12-18 y.o. 70-150mg/dl
- >18 y.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 Type: ______ Follow Collaborative Guidelines for CGM/ICGM (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 Injection Dose: mg Intramuscular in

OR BAQSIMI nasal spray 1 device (3mg) in one nostril

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:

Blood Glucose Correction & Insulin Dosage using Rapid Acting/Short Acting Insulin Type: Injections should be given subcutaneously & rotated

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

Insulin Dosing Attached

☐ Sensitivity/Correction Factor: ______ unit insulin for every ______ mg/dl above ______ starting at ______ mg/dl

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

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☐ Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin per Standards of Care for Diabetes Management in the School Setting – Colorado

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: ____________

Form #201 Colorado Kids with Diabetes Care and Prevention Collaborative August 2020