

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 2014

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	<input type="checkbox"/> >18y.o. 70-130mg/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				

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 <input type="checkbox"/> Arm <input type="checkbox"/> Buttocks <input type="checkbox"/> 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:		

When to Check Blood Glucose: <i>For provision of student safety while limiting disruption to learning</i>				
✓ Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns				
<input type="checkbox"/> Before School Program	<input type="checkbox"/> Before Snack	<input type="checkbox"/> Mid-morning	<input type="checkbox"/> After School Program/Extracurricular Activity	
<input type="checkbox"/> Before Lunch	<input type="checkbox"/> After Lunch	<input type="checkbox"/> Recess	<input type="checkbox"/> Before PE	<input type="checkbox"/> After PE
<input type="checkbox"/> School Dismissal	<input type="checkbox"/> Before riding bus/walking home	<input type="checkbox"/> 2.5 hrs after correction	Other:	

Blood Glucose Correction and Insulin Dosage Using (Rapid Acting/Short Acting) Insulin Type:					
Injection site: <input type="checkbox"/> Abdomen <input type="checkbox"/> Arm <input type="checkbox"/> Buttock <input type="checkbox"/> Thigh			<i>Injections should be given subcutaneously & rotated</i>		
Lunchtime Correction: Give <input type="checkbox"/> Prior to lunch <input type="checkbox"/> Immediately after lunch <input type="checkbox"/> Split ½ before lunch & ½ after lunch <input type="checkbox"/> Other :					
<input type="checkbox"/> Sensitivity/Correction Factor:		_____ unit insulin for every _____ mg/dl above target BG range starting at _____ mg/dl			
Blood Glucose Range:	mg/dl to	mg/dl	Administer:	units	<input type="checkbox"/> Check ketones
Blood Glucose Range:	mg/dl to	mg/dl	Administer:	units	<input type="checkbox"/> Check ketones
Blood Glucose Range:	mg/dl to	mg/dl	Administer:	units	<input type="checkbox"/> Check ketones
Blood Glucose Range:	mg/dl to	mg/dl	Administer:	units	<input type="checkbox"/> Check ketones
Blood Glucose Range:	mg/dl to	mg/dl	Administer:	units	<input type="checkbox"/> Check ketones
Blood Glucose Range:	mg/dl to	mg/dl	Administer:	units	<input type="checkbox"/> Check ketones
<input type="checkbox"/> 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:	
<input type="checkbox"/> 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.	
<input type="checkbox"/> Contact Health Care Provider for One-time order	

Carbohydrates and Insulin Dosage: <input type="checkbox"/> Breakfast <input type="checkbox"/> Snack <input type="checkbox"/> Lunch <input type="checkbox"/> Other:	
Insulin to Carbohydrate Ratio: _____ unit(s) for every _____ grams of carbohydrate to be eaten	
<input type="checkbox"/> Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates	

<input type="checkbox"/> Oral Medication: _____ mg Time: _____	
Dose: _____ units	
<input type="checkbox"/> NPH Insulin SQ Time: _____	
Student's Self Care: <input type="checkbox"/> No supervision <input type="checkbox"/> Full supervision, <input type="checkbox"/> 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: _____

Health Care Provider Orders for Student with Diabetes on Insulin Pump

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 2014

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	<input type="checkbox"/> >18y.o. 70-130mg/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				

Hypoglycemia: Follow Standards of Care for Diabetes Management in the School Setting – Colorado, unless otherwise indicated here: _____		
For Severe Symptoms: Call 911, Disconnect Pump, Administer Glucagon Dose:	mg	Intramuscular in <input type="checkbox"/> Arm <input type="checkbox"/> Buttocks <input type="checkbox"/> 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: _____		

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				
<input type="checkbox"/> Before School Program	<input type="checkbox"/> Before Snack	<input type="checkbox"/> Mid-morning	<input type="checkbox"/> After School Program/Extracurricular Activity	
<input type="checkbox"/> Before Lunch	<input type="checkbox"/> After Lunch	<input type="checkbox"/> Recess	<input type="checkbox"/> Before PE	<input type="checkbox"/> After PE
<input type="checkbox"/> School Dismissal	<input type="checkbox"/> Before riding bus/walking home	<input type="checkbox"/> 2.5 hrs after correction	Other: _____	

Insulin Pump: Follow Guidelines for Insulin Administration by School Staff, Diabetes Resource Nurses February 2013	
<ul style="list-style-type: none"> 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 _____
Correction Bolus:	
<ul style="list-style-type: none"> Provide Correction bolus per pump calculator. All BG levels should be entered into the pump for administration of pump-calculated corrections unless otherwise indicated on the provider orders. 	
<input type="checkbox"/> Sensitivity/Correction Factor:	_____ unit for every _____mg/dl above target BG range starting _____mg/dl insulin at _____
<input type="checkbox"/> If blood glucose is <i>less than</i> <u> </u> mg/dl, wait to give meal bolus until after meal	
When Hyperglycemia occurs other than at lunchtime:	
<input type="checkbox"/> 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.	
<input type="checkbox"/> Contact Health Care Provider for One-time order	

Carbohydrates and Insulin Dosage per pump: <input type="checkbox"/> Breakfast <input type="checkbox"/> Snack <input type="checkbox"/> Lunch <input type="checkbox"/> Other:	
Insulin to Carbohydrate Ratio: _____ unit(s) for every _____ grams of carbohydrate to be eaten	
Bolus for carbohydrates should occur immediately <input type="checkbox"/> Prior to lunch/snack <input type="checkbox"/> After lunch/snack <input type="checkbox"/> Split ½ before lunch & ½ after lunch <input type="checkbox"/>	
Other: _____	
<input type="checkbox"/> Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates	

Pump Malfunctions: Disconnect pump when malfunctioning	
<i>If pump calculator is operational then the insulin dosing should be calculated by using the pump bolus calculator and then insulin given by injection</i>	
If pump calculator is not operational: <input type="checkbox"/> School Nurse or Parent to give insulin according to Insulin to Carbohydrate Ratio and/or Correction Factor	
<input type="checkbox"/> Call Parent and Health Care Provider (for orders)	
Student’s Self Care: <input type="checkbox"/> No supervision <input type="checkbox"/> Full supervision, <input type="checkbox"/> 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: _____