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) divided by Insulin Sensitivity_____] + [# carbohydrates consumed ÷ 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: _____