Health Care Provider Order for Student with Diabetes on Injections

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 alarms ☐ 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** > 300 mg/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, ***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: ___

Blood Glucose Correction and Insulin Dosage Using (Rapid Acting/Short Acting) Insulin Type: ____
Injection site: ☐Abdomen ☐Arm ☐Buttock ☐Other: _____ *Injections should be given subcutaneously & rotated*
To be given at: ☐ Prior to lunch ☐ Immediately after eating lunch ☐ Split ½ before lunch & ½ after lunch
☐ Other : ____
If Correction dose is needed other than at time indicated, School Nurse will contact Health Care Provider for One-time order
☐ Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin *per Guidelines for Insulin Management**

Blood Glucose Range _____ mg/dl Administer _____ units
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Carbohydrates and Insulin Dosage:
Insulin to Carbohydrate Ratio: _____unit(s) for every _____ grams of carbohydrate (or to be) eaten
Correction Factor:_____ unit of insulin for every ___ mg/dl in Blood glucose starting at _____.

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

Medication: Follow *Guidelines for Insulin Administration by School Staff, Diabetes Resource Nurses February 2013*
☐ Oral diabetes medication(s) Dose: _____ mg Times to be given: ____
☐ NPH Insulin Dose: _____ units SQ Times to be given: ____

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: _____