

SCHOOL DIABETES ORDERS – INJECTOR

Licensed Healthcare Provider (LHP) to Complete Annually

NAME: _____ SCHOOL: _____ GRADE: _____

Start date: _____ for 2019-2020 school year Through last day of school Other: _____

LOW BLOOD GLUCOSE (BG) MANAGEMENT

1. If BG is below 70 or having symptoms, give _____ grams fast-acting carbohydrate (i.e. 4 glucose tabs, 4 oz juice).
2. Recheck BG in 15 minutes and repeat carbohydrate treatment if BG still < 80 or if child continues to be symptomatic.
3. Once BG is > 80, may follow with 10-15 gram carb snack, or meal if time. Do not include low treatment in meal carbs.

If unconscious, unresponsive, difficulty swallowing, or evidence of seizure: Phone 911 immediately. Do NOT give anything by mouth. If nurse or trained PDA is available, administer Glucagon (_____ mg SQ or IM)

HIGH BLOOD GLUCOSE (BG) MANAGEMENT

1. Correction with Insulin
 - If BG is over target range _____ for _____ hours after last bolus or carbohydrate intake, student should receive correction dose of insulin per orders, but only cover with carb ratio at the next meal time.
 - Never correct for high blood sugars other than at mealtime, unless consultation with student's LHP (Licensed Healthcare Provider) or as set up by 504 plan
2. Ketones: Test urine ketones if BG > 300 X 2hrs, or Never. Call parent if child is having moderate or large ketones.
3. No exercise if having nausea or abdominal pain, or if ketones are tested and found positive (moderate or large).
4. Encourage student to drink plenty of water and provide rest if needed.

BLOOD GLUCOSE (BG) TESTING / SENSOR GLUCOSE (SG) VIA CONTINUOUS GLUCOSE MONITOR (CGM)

BG to be tested: Before meals and for symptoms of low or high BG, or as set up by the 504 plan.

Extra BG testing: before PE, before going home, Use of SG allowed for CGM users for extra testing

Blood glucose at which parents should be notified: Low < 70 mg/dL after 2 treatments, or High >300 mg/dL X 2 hours

Notify the parents if repeated hypoglycemia, abdominal pain, nausea/vomiting, fever, if hypoglycemic before going home, or if there is a refusal of care by the child. Hyperglycemia is not medically justified for sending home the student, in absence of symptoms.

INSULIN ADMINISTRATION at Mealtime/Snacks Apidra® Humalog® Novolog® FIASP®

Insulin to Carb Ratio: 1 unit per _____ grams Carb
BG Correction Factor: 1 unit per _____ mg/dL > _____

Parent/caregiver authorized to adjust insulin for carbs, BG level, or anticipated activity
 Licensed medical personnel authorized to adjust the insulin dose by +/- 0 to 5 units after consultation with parent/caregiver

Pre-meal BG target: 70-_____, or Other: _____
Insulin dosing to be given: before, or after meal
 after meal dosing when before meal BG < 80 mg/dL

STUDENT'S SELF-CARE *Healthcare Provider to Initial Ability Level*

| | | | | | |
|---|--|--------------------------|---|--|--------------------------|
| 1. | Totally independent diabetes management | <input type="checkbox"/> | 4. | Student consults with nurse/PDA for insulin dose or | <input type="checkbox"/> |
| 2. | Student needs BG/SG verification of number by staff or | <input type="checkbox"/> | | Student self-injects insulin with nurse/PDA or designated staff supervision only or | <input type="checkbox"/> |
| | Assist BG testing to be done by school nurse/PDA/designated staff | <input type="checkbox"/> | | Injection to be done by school nurse/PDA | <input type="checkbox"/> |
| 3. | Student consults with nurse/PDA or designated staff for carbohydrate count | <input type="checkbox"/> | | | |
| If patient wears Dexcom G5 or G6 CGM per SG reading. Test BG if symptoms or expectations do not match SG. Refer to Dexcom training materials | | | If patient wears Medtronic or Dexcom G4 CGM; Insulin per orders based on BG reading only per FDA | | |

DISASTER PLAN ORDERS

Parent is responsible for providing and maintaining "disaster kit" and to notify school nurse. In case of disaster:

Use above BG correction scale + carb ratio coverage for disaster insulin dosing every 3-4 hrs.

If long-acting insulin is not available, then administer rapid-acting insulin every 3-4 hrs as indicated by BG levels.

Signed by: _____ Date: _____

I authorize the exchange of medical information about my child's diabetes management between the LHP and the school nurse

I do not authorize the exchange of medical information about my child's diabetes management between the LHP and the school nurse

Parent Signature: _____ Print Name: _____ Date: _____

School Nurse Signature: _____ Print Name: _____ Date: _____