SCHOOL DIABETES ORDERS - INJECTOR

Licensed Healthcare Provider (LHP) to Complete Annually

NAME: ______________________________ SCHOOL: __________________ GRADE: __________

Start date: ____________ for ____________ school year [x] 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

Administer Baqsimi 3mg nasal spray if nurse/designated staff is available. **OR**

If nurse/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/blood 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.

1. **BLOOD GLUCOSE (BG) TESTING / SENSOR GLUCOSE (SG) VIA CONTINUOUS GLUCOSE MONITOR (CGM)**
2. BG to be tested: [x] Before meals and for symptoms of low or high BG, or as set up by the 504 plan.
3. Extra BG testing: [ ] before PE, [x] before going home, [x] Use of SG allowed for CGM users for extra testing
4. **Blood glucose at which parents should be notified**: Low < 70 mg/dL after 2 treatments, or High >300 mg/dL X 2 hours
5. 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 student. Hyperglycemia alone is not medically justified for sending home @FNAME@ in absence of symptoms.

INSULIN ADMINISTRATION at *Mealtime/Snacks* [ ] Apidra [ ] Humalog [ ] Novolog [ ] FIASP

Insulin to Carb Ratio: 1 unit per _______ grams Carb	*Pre-meal* BG target: [x] 70-_____, or [ ] Other: _______
BG Correction Factor: 1 unit per _______ mg/dL > _______	Insulin dosing to be given: [ ] before, or [ ] after meal
[x] Parent/caregiver authorized to adjust insulin for carbs, BG level, or anticipated activity	[x] after meal dosing when before meal BG < 80 mg/dL

[x] Licensed medical personnel authorized to adjust the insulin dose by +/- 0 to 5 units after consultation with parent/caregiver

STUDENT'S SELF-CARE

1.	Totally independent diabetes management	[ ]	**4.**	Student consults with nurse/PDA for insulin dose **or**	[ ]
2.	Student needs BG/SG verification of number by nurse/PDA/designated staff **or**	[ ]		Student self-injects insulin with nurse/PDA/ designated staff supervision only **or**	[ ]
	Assist BG testing to be done by nurse/PDA	[ ]		Injection to be done by school nurse/PDA	[ ]
3.	Student consults with nurse/PDA/designated staff for carbohydrate count	[ ]			

If patient wears **Dexcom G5, G6 or FreeStyle Libre** CGM insulin dose per orders based on SG reading per FDA. Test BG if no number, no arrow trend, or if symptoms/expectations do not correlate with SG reading.	If patient wears **Medtronic Guardian Connect** 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.

Electronically signed by LHP: ______________________________ Date: ________________ Fax: ______________

I 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: ______________

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PARENT/GUARDIAN SECTION

EMERGENCY CONTACTS

Name
Home Phone
Work Phone
Other

Name
Home Phone
Work Phone
Other

ADDITIONAL EMERGENCY CONTACTS:

1.	Relationship:	Phone:
2.	Relationship:	Phone:

****Does the student need classroom, school activity, or recess accommodations? ___yes ___no. If yes, please contact the school counselor.**

- A new health care plan for health conditions must be submitted each school year.
- I understand that if any changes are needed on the HCP, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other non-school programs of their child's health condition.
- Medical information may be shared with school staff working with your child and 911 staff, if they are called.
- I have reviewed the information on this health care plan and request/authorize trained school employees to provide this care in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I understand this plan can only be discontinued by the LHP.
- I authorize the exchange of information about my child's health condition between the LHP office and the school nurse.
- *My signature below shows I have reviewed and agree with this health care plan.*

Parent/Guardian Signature Date

For District Nurse's Use Only		
School Nurse Signature	**Date**	**Phone:**

Health care plan and medication (if prescribed) must accompany student on any field trip or school activity.

*****Keep plan readily available for substitutes.*****