

# SCHOOL DIABETES ORDERS - INJECTOR

Licensed Healthcare Provider (LHP) to Complete Annually

NAME: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

Start date: \_\_\_\_\_ for 2020-2021 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 -or- Baqsimi 3mg/nasal spray**

## 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:  Before meals and for symptoms of low or high BG, or as set up by the 504 plan.
3. Extra BG testing:  before PE,  before going home,  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:  70-\_\_\_\_\_, or  Other: \_\_\_\_\_

**BG Correction Factor:** 1 unit per \_\_\_\_\_ mg/dL > \_\_\_\_\_ Insulin dosing to be given:  before, or  after meal

Parent/caregiver authorized to adjust insulin for carbs, BG level, or anticipated activity  after meal dosing when before meal BG < 80 mg/dL

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

## STUDENT'S SELF-CARE

<p>1. Totally independent diabetes management <input type="checkbox"/></p> <p>2. Student needs BG/SG verification of number by nurse/PDA/designated staff <b>or</b> Assist BG testing to be done by nurse/PDA <input type="checkbox"/></p> <p>3. Student consults with nurse/PDA/designated staff for carbohydrate count <input type="checkbox"/></p>	<p>4. Student consults with nurse/PDA for insulin dose <b>or</b> Student self-injects insulin with nurse/PDA/designated staff supervision only <b>or</b> Injection to be done by school nurse/PDA <input type="checkbox"/></p>
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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: \_\_\_\_\_ 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: \_\_\_\_\_

**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.\*\***