Tippecanoe School Corporation
Diabetes Management Orders

Student: _____ **DOB:** _____
School: _____ **Grade:** _____

CONTACT INFORMATION:
Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell: _____
Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell: _____
Other Contact: _____ Home Phone: _____ Work: _____ Cell: _____

INSULIN ORDERS:
1. Insulin administration via:
   - □ Syringe and vial □ Insulin pen □ Insulin pump □ Other: _____
   - If pump, type of pump: _____ Basal rates: _____

2. Insulin meal coverage:
   - □ Routine breakfast dose: _____
   - □ Routine lunch dose: _____
   - □ Calculated insulin dose (add carbohydrate coverage and correction dose for total insulin dose):
     - Carbohydrate coverage: Insulin to carbohydrate ratio
     - Breakfast: Give _____ unit(s) insulin per _____ gms carbohydrate
     - Lunch: Give _____ unit(s) insulin per _____ gms carbohydrate
     - Snack: Give _____ unit(s) insulin per _____ gms carbohydrate
     - Dinner: Give _____ unit(s) insulin per _____ gms carbohydrate
     - Correction dose:
     - Give _____ unit(s) insulin per _____ mg/dL of glucose ABOVE _____ mg/dL
     - Subtract _____ unit(s) insulin per _____ mg/dL of glucose BELOW _____ mg/dL
   - □ Insulin may be given after lunch if _____

3. Other times insulin may be given:
   - □ Snack Dose: _____ Calculated as above
   - □ Blood glucose above _____ mg/dL ___ hrs after last dose give _____
   - □ Ketones: If ketones are _____ drink _____ oz of water every _____
     If ketones are _____ give/add _____ unit(s)
     If ketones are _____ give/add _____ unit(s)

Health Care Provider Authorization for Management of Diabetes in School

My signature below provides authorization for the above written orders. This authorization is for a maximum of one school year. If changes are indicated, I will provide new written authorization, which may be faxed.

Health Care Provider Name: _____
Signature:_____ **Date:** _____(original or stamped signature – sign all pages)
Address: _____
City: _____ **Zip:** _____
Phone: _____ **Fax:** _____

Parent Consent for Management of Diabetes in School

I (We) request designated school personnel to administer the medication and treatment orders as prescribed above. I agree:

1. To provide the necessary supplies and equipment
2. To notify the school nurse if there is a change in the student's diabetes management or health care provider.
3. To allow trained Volunteer Health Aides to participate in the student's diabetes management as provided in the Care of Students with Diabetes Act (IC 20-34-5)

I authorize the school nurse to communicate with the health care provider as necessary.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ Date:_____

Order reviewed and signed by School Nurse: _____ Date: _____

Student: _____ Date: _____

BLOOD GLUCOSE MONITORING:

Target range for blood glucose: _____ mg/dL to _____ mg/dL

□ Before meals □ 2 hours or _____ hours after breakfast
□ Before snacks □ 2 hours or _____ hours after lunch
□ As needed for symptoms of hypo/hyperglycemia
□ When having signs and symptoms of illness
□ Before exercise □ Before recess □ Before getting on bus
□ Other times:

HYPOGLYCEMIA – blood glucose less than _____ mg/dL

□ Self-treatment for mild lows
□ Give _____ grams of fast-acting carbohydrate according to care plan. Recheck blood glucose in 15 minutes. Repeat treatment if blood glucose is less than _____ mg/dL
□ Provide extra protein and carbohydrate snack after treating low if next meal/snack greater than _____ minutes away.
□ Suspend pump for severe hypoglycemia (blood glucose less than _____ mg/dL) for _____ minutes

If student is unconscious, having a seizure or unable to swallow, presume student has a low blood sugar and:

Call 911, notify parent

□ **Glucagon injection (1 mg/ml) _____ mg,** □ **subcutaneous or** □ **intramuscular**
□ **OK to use glucose gel inside cheek, even if unconscious or seizing**
□ **Other:**

HYPERGLYCEMIA – blood glucose greater than _____ mg/dL:

□ Check urine ketones, follow care plan, administer insulin as per orders
□ For pumps, assess pump fuction, administration set, and insertion site. If corrective bolus does not work, site should be changed. Insulin may be given by syringe or pen if needed
□ Encourage sugar free fluids, at least _____ oz every _____
□ If student complains of nausea, vomiting or abdominal pain, check urine ketones and check insulin administration orders
□ Other: _____

MEAL PLAN:

□ AM snack, time: _____ □ PM snack, time: _____ □ Avoid snack if blood glucose is over _____ mg/dL
□ Breakfast: _____ □ Lunch: _____ □ Dinner: _____
□ Extra food allowed: □ Parent's discretion □ Student's discretion

EXERCISE (check and complete all that apply):

Fast-acting carbohydrate source must be available before, during, and after all exercise.
□ With student □ With teacher
If most recent blood glucose is less than _____ mg/dL, exercise can occur when blood glucose is corrected and above _____ mg/dL
□ Eat _____ grams of carbohydrate:
□ Before □ Every 30 minutes during □ After vigorous exercise
□ Avoid exercise when blood glucose is greater than _____ mg/dL or ketones are _____

Health Care Provider's Signature: _____ Date: _____

Parent's Signature:_____ **Date:** _____

Order reviewed and signed by school nurse: _____ Date: _____

Student: _____ **Date:** _____

BUS TRANSPORTATION:

- □ Blood glucose monitoring not required prior to boarding bus
- □ Check blood glucose _____ minutes prior to boarding bus
- □ Allow student to eat on bus if having symptoms of low blood sugar
- □ Student may not ride bus if blood glucose is below _____ mg/dL or above _____ mg/dL
- □ Provide care as follows:

_____

HEALTH CARE PROVIDER ASSESSMENT:

Student can self-perform the following procedures (school nurse and parent must verify competency):

- □ Blood glucose monitoring
- □ Measuring insulin
- □ Injecting insulin
- □ Determining insulin dose
- □ Independently operating insulin pump
- □ Other:

_____

DISASTER PLAN (if needed for lockdown, 24 hr shelter in place):

- □ Follow insulin orders on management form
- □ Additional insulin orders as follows: _____
- □ Administer long acting insulin as follows: _____
  (must be provided by parent if needed)
- □ Other: _____

OTHER INSTRUCTIONS:

_____

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Health Care Provider's Signature: _____ **Date:** _____

Parent's Signature:_____ **Date:** _____

Order reviewed and signed by school nurse: _____ Date: _____