Diabetes Information/Orders from Physician

For Students Without Pump

Date_______________________________

Student Name ____ **DOB** ___________**School** ___________________________________
Physician:____**Office Phone:**____
Diabetes Educator: _______________________________________ **Pager:** __________________**Phone:** _______________________________
Diagnosis:____

I. General Orders:

A. Blood Glucose Goal Range ______ to ______mg/dl
Call parents if student's blood sugar:
is below______
above ______
urine ketones present ______

B. Times for glucose testing ____ breakfast ____snack ____lunch ____ snack ____dinner ____bedtime
and prn symptoms of hypoglycemia.

C. Current Insulin orders or see attached sheet ____________________________________
- □ Food/Meal Bolus: _____ units of insulin for every _____ grams of carbohydrate.
- □ Correction Factor Bolus for hyperglycemia: _____ units of insulin for every _____ mg/dl over _____ mg/dl.
(round to nearest half unit depending on device)

D. Other medications: ____

E. Check blood glucose prior to physical activities? □ yes □ no

F. Special instructions regarding physical activity; PE, recess, field trips, track day, etc.
Check if appropriate:
- □ Blood Sugar testing ____
- □ Snack ____
- □ Exclude from activity if ketones are greater than _____.

G. Level of Diabetic Self Care approved by physician/provider:

Student Alone	Student with Supervision	Student Requires Assistance	
_____	______	______	Perform own blood sugar checks
_____	______	______	Count carbohydrates
_____	______	______	Determine correct amount of insulin
_____	______	______	Draw correct amount of insulin
_____	______	______	Give own injections
_____	______	______	Check urine ketones

H. Student has been instructed regarding:
Yes/No Signs and symptoms in recognizing hypoglycemia and hyperglycemia
Yes/No Universal precautions
Yes/No Proper disposal of sharps

II. Emergency Orders:
Check one:

A. _____ Use standard treatment plan as attached: □ Physician's Hyperglycemia Treatment Plan □ Physician's Hypoglycemia Treatment Plan

B. _____ See attached MD orders

III. Physician Signature:
These orders as indicated above will be in effect for the current school year unless otherwise noted.

________________________________ ____________________
Physician Signature **Date**

IV. School Signatures:

A. School Nurse/Clinical Manager:
I have reviewed the order for safe implementation. The date for renewal/review is __________.

____________________________________ ____________________
School Nurse/Clinical Manager **Date**

B. School Principal:
I have accepted the order to be carried out by the school nurse/trained personnel in my school.

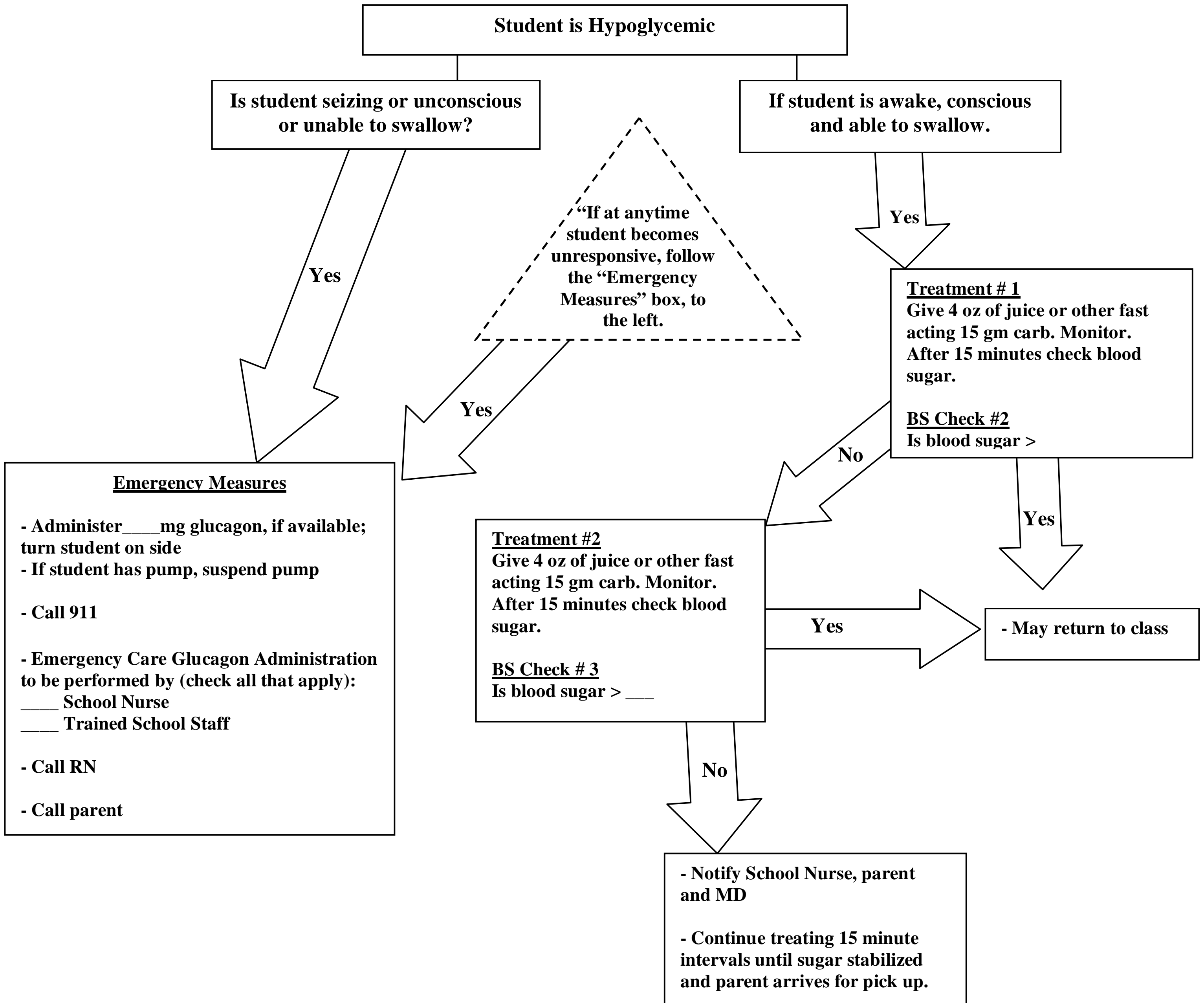
____________________________________ ____________________
School Principal Signature **Date**

Physician's Hypoglycemia Treatment Plan

Student's Name: ______________________________________ Date: ______________

Physician's Name: _____________________________________

Blood sugar less than _____ will be considered hypoglycemia for this child.

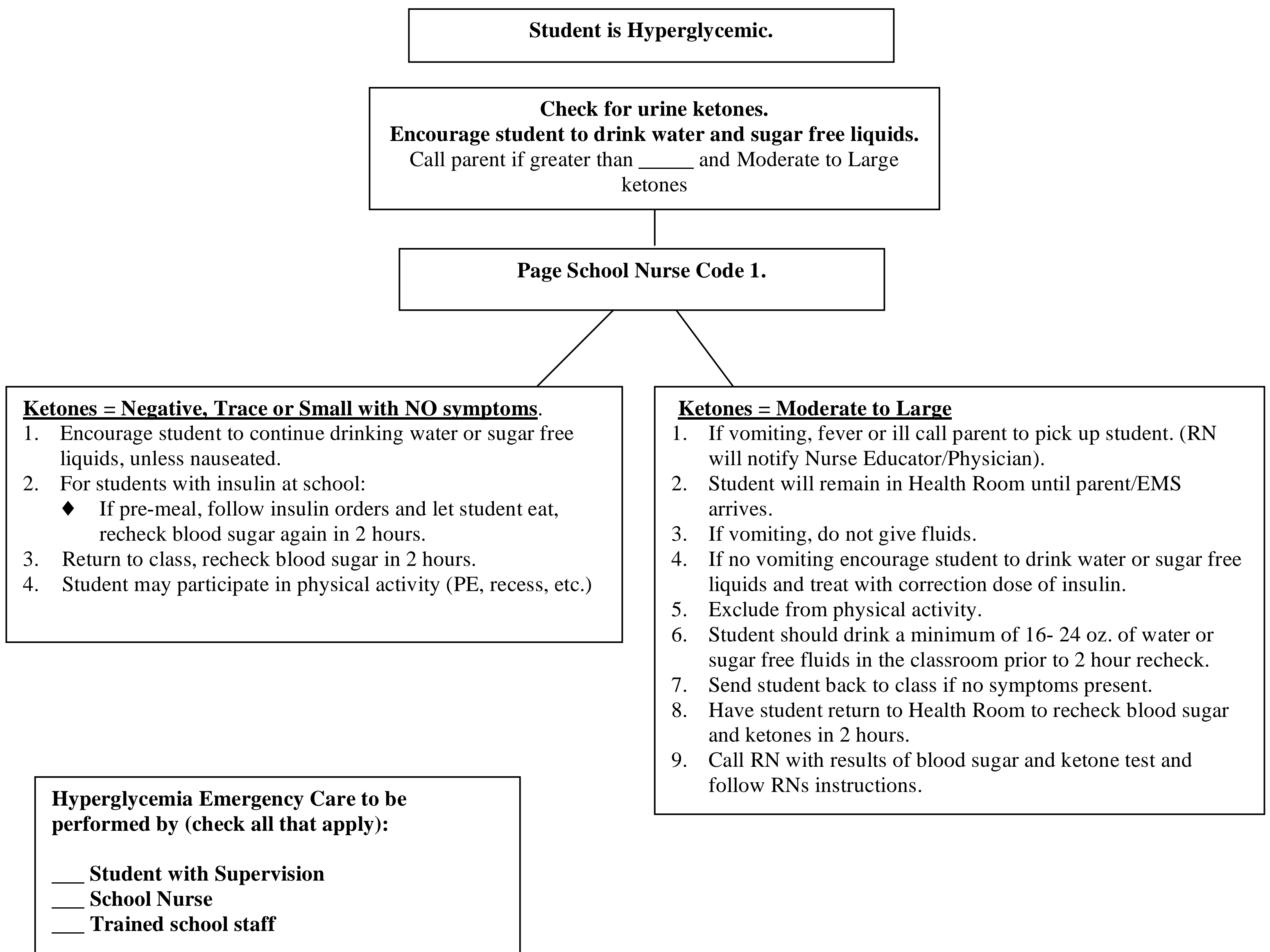


Physician's Hyperglycemia Treatment Plan

Student's Name: ______________________________________ Date: ______________

Physician's Name: _________________________

Blood sugar greater than _____ will be considered hyperglycemia for this child.



Student is Hyperglycemic.

Check for urine ketones.
Encourage student to drink water and sugar free liquids.
Call parent if greater than _____ and Moderate to Large ketones

Page School Nurse Code 1.

Ketones = Negative, Trace or Small with NO symptoms.

1. Encourage student to continue drinking water or sugar free liquids, unless nauseated.
2. For students with insulin at school:
   - If pre-meal, follow insulin orders and let student eat, recheck blood sugar again in 2 hours.
3. Return to class, recheck blood sugar in 2 hours.
4. Student may participate in physical activity (PE, recess, etc.)

Ketones = Moderate to Large

1. If vomiting, fever or ill call parent to pick up student. (RN will notify Nurse Educator/Physician).
2. Student will remain in Health Room until parent/EMS arrives.
3. If vomiting, do not give fluids.
4. If no vomiting encourage student to drink water or sugar free liquids and treat with correction dose of insulin.
5. Exclude from physical activity.
6. Student should drink a minimum of 16- 24 oz. of water or sugar free fluids in the classroom prior to 2 hour recheck.
7. Send student back to class if no symptoms present.
8. Have student return to Health Room to recheck blood sugar and ketones in 2 hours.
9. Call RN with results of blood sugar and ketone test and follow RNs instructions.

Hyperglycemia Emergency Care to be performed by (check all that apply):

___ Student with Supervision
___ School Nurse
___ Trained school staff