

# Maryland State Management of Diabetes at School/Order Form

This order is valid only for the Current School Year: \_\_\_\_\_ (including summer session)

<b>Student:</b> _____	<b>DOB:</b> _____
<b>School:</b> _____	<b>Grade:</b> _____

**CONTACT INFORMATION**

Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell/pager: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell/pager: \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_

**Insulin Orders (complete only if insulin is needed at school):**

1. Insulin administration via:

Syringe and vial     Insulin pen     Insulin pump     Other \_\_\_\_\_

Insulin pump                      Type of pump: \_\_\_\_\_                      Basal rates: \_\_\_\_\_

2. Insulin Before Lunch/Meals:                      Name of Insulin: \_\_\_\_\_

Routine lunchtime dose: \_\_\_\_\_

Per sliding scale as follows:

Meals

Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units
Blood Glucose _____	to	_____	give	_____ units

Calculated insulin dose (add carbohydrate coverage and correction dose for total insulin dose):

Carbohydrate Coverage: Insulin to carbohydrate ratio

Give \_\_\_\_\_ # unit(s) insulin per \_\_\_\_\_ gms carbohydrate.

Correction:

Give \_\_\_\_\_ # unit(s) insulin per \_\_\_\_\_ mg/dl of glucose **above** \_\_\_\_\_ mg/dl

Subtract \_\_\_\_\_ # units for every \_\_\_\_\_ mg/dl of glucose **below** \_\_\_\_\_ mg/dl

Insulin may be given after lunch if \_\_\_\_\_

3. Other times insulin may be given:

<input type="checkbox"/> Snack:      Dose: _____	<input type="checkbox"/> Calculated as above.	<input type="checkbox"/> Snack:	
<input type="checkbox"/> Ketones:      If ketones are _____	Give/Add: _____ unit(s)	Blood Glucose	Give: _____ units
If ketones are _____	Give/Add: _____ unit(s)	_____	_____ units
		_____	_____ units

**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:** \_\_\_\_\_ (original or stamped signature) **\*Sign both sides.**

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Use for Prescriber's Address Stamp

**Parent Consent for Management of Diabetes at 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.

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

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **\*Sign both sides.**

\_\_\_\_\_ **Date** \_\_\_\_\_

Order reviewed and signed by School Nurse (per local policy):

Date:

**Maryland State Management of Diabetes at School/Order Form**

**Student:** \_\_\_\_\_

**Blood Glucose Monitoring:**

**Target range for blood glucose monitoring at school:** \_\_\_\_\_

- Before snacks                       2 hours or \_\_\_\_\_ hours after lunch
- Before meals                          2 hours or \_\_\_\_\_ hours after a correction dose
- As needed for symptoms of hypo/hyperglycemia
- With signs and symptoms of illness
- Other times: \_\_\_\_\_

**Hypoglycemia – blood glucose less than \_\_\_\_\_**

- Self treatment for mild lows.
- Give \_\_\_\_\_ grams of fast-acting carbohydrate according to care plan. Recheck BG in 10-15 mins. Repeat treatment if BG less than \_\_\_\_mg/dl
- Provide extra protein & carbohydrate snack after treating low if next meal/snack greater than \_\_\_\_\_ minutes away
- Suspend pump for severe hypoglycemia for \_\_\_\_\_ mins.

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

**Call 911, notify parent**

- Glucagon injection (1 mg in 1 cc) \_\_\_\_\_ mg, subcutaneously or intramuscular (IM)**
- OK to use glucose gel inside cheek, even if unconscious, seizing.**
- Other:** \_\_\_\_\_

**Hyperglycemia – blood glucose greater than \_\_\_\_\_**

- Check urine ketones, follow care plan, administer insulin as per orders.                       For pumps, insulin may be given by syringe or pen if needed.
  - Encourage sugar free fluids, at least \_\_\_\_\_ ounces per \_\_\_\_\_.
  - If student complains of nausea, vomiting or abdominal pain; check urine ketones & check insulin administration orders.
  - Other: \_\_\_\_\_
- \* Transport to local Emergency Room may be needed with vomiting and large ketones.

**Meal Plan**

- AM snack, time: \_\_\_\_\_                       PM snack time: \_\_\_\_\_                       Avoid snack if blood glucose greater than \_\_\_\_\_ mg/dl.
- Lunch: \_\_\_\_\_
- Extra food allowed;    Parent's discretion;    Student's discretion

**Exercise (check and/or 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 \_\_\_\_\_, exercise can occur when blood glucose is corrected and above \_\_\_\_\_.
- Eat \_\_\_\_\_ grams of carbohydrate                       Before                       Every 30 mins during                       After vigorous exercise
- Avoid exercise when blood glucose is greater than \_\_\_\_\_ or ketones are \_\_\_\_\_

**Bus Transportation**

- Blood glucose monitoring not required prior to boarding bus
- Check blood glucose 15 minutes prior to boarding bus
- Allow student to eat on bus if having symptoms of low blood glucose
- 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 as on Management Form
- Additional insulin orders as follows: \_\_\_\_\_
- Administer long acting insulin as follows: \_\_\_\_\_
- Other: \_\_\_\_\_

**Other instructions:**

\_\_\_\_\_

Health Care Providers Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Order reviewed by School Nurse (per local policy): \_\_\_\_\_ Date: \_\_\_\_\_

## Maryland State Supplemental Form for Students with Insulin Pumps

This order is valid only for the Current School Year: \_\_\_\_\_ (including summer session)

<b>Student:</b> _____	<b>DOB:</b> _____
<b>School:</b> _____	<b>Grade:</b> _____

### CONTACT INFORMATION:

Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell/pager: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell/pager: \_\_\_\_\_  
 Pump Resource Person: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Other Emergency Contact: \_\_\_\_\_

### Pump Management

Type of pump: \_\_\_\_\_ Start Date for Pump Therapy: \_\_\_\_\_  
 Type of Insulin in pump: \_\_\_\_\_

Basal rates: \_\_\_\_\_ 12am to \_\_\_\_\_ Comment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Insulin/carbohydrate ratio: \_\_\_\_\_ Check Management of Diabetes at School Order or correction factor  
 Hyperglycemia:  
 \_\_\_\_\_ Pump site should be changed if BG greater than \_\_\_\_\_ times \_\_\_\_\_  
 \_\_\_\_\_ Insulin should be given by syringe or pen if needed \_\_\_\_\_

### Management Skills of Student

- As verified by school nurse, health care provider and parent Independent?

Count carbohydrates	__ yes	__ no
Calculate an insulin dose	__ yes	__ no
Bolus an insulin dose	__ yes	__ no
Reset basal rate profiles	__ yes	__ no
Set a temporary basal rate	__ yes	__ no
Disconnect pump	__ yes	__ no
Reconnect pump at infusion set	__ yes	__ no
Prepare infusion set for insertion	__ yes	__ no
Insert infusion set	__ yes	__ no
Troubleshoot alarms and malfunctions	__ yes	__ no
Give self injection if needed	__ yes	__ no
Change batteries	__ yes	__ no

\_\_ Student is non-independent Child Lock On? Yes No

### Pump Supplies

Extra supplies needed include: Infusion sets, reservoir/cartridges, insertion device, insulin vial & syringes, batteries  
 Location of supplies: \_\_\_\_\_

### Disaster Plan (If needed for lockdown, etc):

- Follow Insulin orders as on Management Form
- Insulin doses as follows: \_\_\_\_\_

Other: \_\_\_\_\_

**Health Care Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Order reviewed by School Nurse (per local policy):** \_\_\_\_\_ **Date:** \_\_\_\_\_