BEREA CITY SCHOOL DISTRICT

Healthcare Provider Orders for Student with Diabetes

Student Name _____ Birthdate: _____

(Please fill in all blanks and check appropriate options)

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Monitor Blood Glucose: Before lunch and as needed for signs/symptoms of hyper/hypoglycemia

- ☐ Notify parent when blood glucose is less than _____ or greater than _____
- ☐ Target range for blood sugar is greater than _____ but less than _____
- ☐ Student is on pump.
- ☐ Student is on injectable insulin.

HYPOGLYCEMIA Student should not be sent to clinic unaccompanied if symptomatic or if BS less than_____

- ☐ Check blood glucose- if blood glucose meter is not available: Treat symptoms.
- ☐ Blood glucose below _____**mg/dl and or symptomatic:** Treat with **10-15 gm carbohydrate** (juice, glucose tabs, etc)
- ☐ **Mild** symptoms: Treat with **10-15 gm carbs** (juice, glucose tabs, etc) and retest **every 15 minutes** until above _____ **mg/dl** then snack or lunch
- ☐ **Moderate** symptoms if **unable** to drink juice. Administer **glucose gel.** Repeat blood sugar every 15 minutes until above _____**mg/dl,** then snack or lunch.
- ☐ **Severe** symptoms which may include seizures, unconsciousness, and inability and unwillingness to take gel or juice: Administer **Glucagon 1 IM** if trained staff available and **call 911.**

HYPERGLYCEMIA

- ☐ Check urine ketones if blood sugar is over _____**mg/dl or symptoms of illness/vomiting. If ketones present,** call parents, provide water and student **SHOULD NOT** exercise. Student may need insulin via injections.
- ☐ Use **insulin orders** (as stated below) when blood sugar is greater than _____**mg/dl and retest in** _____ **minutes.**
- ☐ Recommend student be released from school when ketones are moderate/large with vomiting which needs to be treated or monitored more closely by parent/guardian.

MEDICATION

Student is on _____ insulin. Time(s) to be given _____

Blood glucose correction and insulin dosage using _____ **insulin.**

Correction Factor or Insulin Sensitivity Factor while at school:

1 unit for every _____blood glucose reading greater than _____mg/dl

Blood Glucose Range	Units of Insulin to be Administered
	1
	2
	3
	4
	5
	6
	7
	8

Carb Ratio 1 unit/ _____ gm CHO while at school

	Units to be Administered
	1
	2
	3
	4
	5

Student's self- care: (ability to be determined by **school nurse** and **parent** with input by health care provider).

Please note all testing whether monitored or independently optimally should take place in the clinic to minimize the risk of blood borne pathogens in accordance with BCSD policy

Task	yes	no
• Totally independent management (if yes, complete self- management agreement)		
• Independent in testing but will verify blood glucose meter will trained staff		
• Assistance with testing required		
• Administered insulin independently		
• Self- injects, whether with pump, pen or syringe, with verification of dose		
• Self -injects ,whether with pump, pen or syringe, with trained staff supervision		
• Injections or pump manipulation to be done by trained staff		
• Independently counts carbohydrates		
• Requires carbohydrate counting assistance from trained staff		
• Interprets urine ketones independently		
• Assistance with interpreting urine ketones required		

SIGNATURES:

My signature below provides authorization for the above written orders and exchange of healthcare information to assist the school nurse in developing an IHP. I understand that all procedures will be implemented in accordance with states laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse or school health coordinator. This order is good for one school year.

Provider: _____ Date_____

Provider phone number: _____ Fax Number: _____

Parent Signature: _____ Date:_____

School Nurse Signature: _____ Date:_____