Prince George's County Public Schools
Management of Diabetes at School/Order Form

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

Student: _____ **DOB:** _____

School: _____ **Grade:** _____

CONTACT INFORMATION

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell: _____

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell: _____

Other Emergence Contact: _____

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

1. Insulin administration via:
   - ☐ Syringe and vial ☐ Insulin pen ☐ Insulin pump ☐ Other
   - • If pump is used, use "Supplemental Information Form for Students with Pumps"
2. Insulin Before Lunch/Meals:
   - ☐ Routine lunchtime dose: _____
   - ☐ Per sliding scale as follows:

Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units
Blood Glucose from	_____	to	_____/_____	Units

☐ Calculated Insulin dose (add correction dose and carbohydrate coverage for total insulin dose):
Coverage: Insulin to carbohydrate ration:
Give _____ # unit(s) insulin per _____ gms carbohydrate.
Correction: Give _____ unit(s) for every _____ mg/dl of glucose above _____ mg/dl

3. Other times insulin may be given:
   - ☐ Snack: Dose: _____ ☐ Calculated as above: _____
   - ☐ Ketones: If ketones are _____ Give: _____ unit(s)
     If ketones are _____ Give: _____ 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:** _____ (original or stamped signature)

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 _____

_____ Date _____

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

Student: _____ Management of Diabetes at School

Blood Glucose Monitoring:

Target range for blood glucose monitoring at school: _____

- ☐ Before Snacks
- ☐ Before meals
- ☐ As needed for symptoms of hypo/hyperglycemia
- ☐ With signs and symptoms of illness
- ☐ Other times: _____
- ☐ 2 hours after lunch
- ☐ 2 hours after a correction dose

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. Repeated treatment if BG less than _____mg/dl.
- ☐ Provide extra protein & carbohydrate snack after treating low if next meal/snack greater than 1 hour away
- ☐ Check supplemental order for students with insulin pumps
- ☐ Suspend pump for severe hypoglycemia

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) _____ mgm, subcutaneously
- ☐ OK to use glucose gel inside cheek, even if unconscious, seizing.
- ☐ Other: _____

Hyperglycemia – blood glucose greater than _____

- ☐ Check urine ketones, follow care plan
- ☐ 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

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 From
- ☐ Administer insulin 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: _____

Prince George's County Public Schools
Supplemental Form for Students with Insulin Pumps

This order is valid only for the current School Year: _____ (including summer session)

Student: _____ **DOB:** _____

School: _____ **Grade:** _____

CONTACT INFORMATION

Parent/Guardian: _____ Home Phone: _____ Cell/Pager: _____

Parent/Guardian: _____ Home Phone: _____ 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:

	12 am to		Comment:
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Insulin/carbohydrate ratio: _____ *Check Management of Diabetes at School Order Form for 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 Students

- 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: _____

Others: _____

Health Care Providers Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

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