

Demographics				
Student Name:	DOB:	Grade:	Diagnosis:	
Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:	
Insulin Orders				
<b>Insulin Dosing:</b>				
<input type="checkbox"/> Carbohydrate coverage	<input type="checkbox"/> Correction dose only	<input type="checkbox"/> Correction dose plus CHO coverage	<input type="checkbox"/> Fixed dose	<input type="checkbox"/> Fixed insulin dose with dosing scale
<input type="checkbox"/> See attached dosing scale				
<b>Insulin(s):</b>				
<input type="checkbox"/> <b>Rapid Acting:</b> <input type="checkbox"/> Apidra <input type="checkbox"/> Humalog <input type="checkbox"/> Novolog <input type="checkbox"/> Any of the <b>rapid acting</b> insulins may be substituted for the others				
<input type="checkbox"/> <b>Long Acting</b> (if given at school): _____ Give _____ unit(s) at _____ (time)				
<b>Insulin Delivery:</b> <input type="checkbox"/> Pen <input type="checkbox"/> Syringe <input type="checkbox"/> Pump (make/model):				
<b>Carbohydrate (CHO) Coverage per meal:</b>				
<input type="checkbox"/> _____ unit(s) of insulin SQ per _____ grams of CHO at breakfast <input type="checkbox"/> _____ unit(s) of insulin SQ per _____ grams of CHO at lunch				
<b>Carbohydrate Dose Adjustment Prior To Strenuous Exercise:</b>				
<input type="checkbox"/> Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at breakfast				
<input type="checkbox"/> Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at lunch				
<b>Correction Dose:</b>				
<input type="checkbox"/> Give _____ unit(s) of insulin SQ for every _____ mg/dl greater than target BG of _____ mg/dl				
<input type="checkbox"/> If pre-meal BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose				
<input type="checkbox"/> <b>Fixed Dose Insulin:</b> _____ unit(s) of insulin SQ given before school meals				
<input type="checkbox"/> <b>Split Insulin Dose:</b> Give _____ unit(s) or _____% of meal insulin dose SQ before meal and _____ unit(s) or _____% of meal insulin dose SQ after meal				
<b>Snack Insulin Coverage:</b>				
<input type="checkbox"/> _____ unit(s) of insulin SQ per _____ grams of CHO in snack <input type="checkbox"/> _____ unit(s) of insulin SQ for snack greater than _____ grams of CHO				
Ketone Coverage				
<b>For ketones <u>trace to small</u> (urine)/&lt; _____ mmol/L (blood)</b>		<b>For ketones <u>moderate to large</u> (urine)/&gt; _____ mmol/L (blood)</b>		
<input type="checkbox"/> Correction dose plus _____ unit(s) of insulin		<input type="checkbox"/> Correction dose plus _____ unit(s) of insulin		
<input type="checkbox"/> _____ unit(s) of insulin		<input type="checkbox"/> _____ unit(s) of insulin		
Insulin Dose Administration Principles				
Insulin should be given:				
<input type="checkbox"/> Before meals <input type="checkbox"/> Before snacks <input type="checkbox"/> Other times (please specify):				
<input type="checkbox"/> For hyperglycemia if BG > _____ mg/dl and _____ hours since last dose/bolus				
<input type="checkbox"/> If CHO intake cannot be predetermined, insulin should be given no more than _____ minutes after start of meal/snack				
<input type="checkbox"/> If parent requests, insulin should be given no more than _____ minutes after start of meal/snack				
<input type="checkbox"/> Use pump or bolus device calculations per programmed settings, once settings have been verified				
<input type="checkbox"/> Parent has permission to increase/decrease insulin correction dose by +/- _____ unit(s) or by ratio _____ unit(s) to _____ mg/dl				
<input type="checkbox"/> Parent has permission to increase/decrease CHO coverage by +/- _____ unit(s) of insulin or by ratio of _____ unit(s) to _____ grams of CHO				
Independent Insulin Administration Skills & Supervision Needs*    *Skills to be verified by school nurse				
<input type="checkbox"/> Insulin dose calculations		<input type="checkbox"/> Carbohydrate counting		<input type="checkbox"/> Measuring insulin
<input type="checkbox"/> Independent <input type="checkbox"/> With Supervision		<input type="checkbox"/> Independent <input type="checkbox"/> With Supervision		<input type="checkbox"/> Insulin administration
				<input type="checkbox"/> Independent <input type="checkbox"/> With Supervision
Other Diabetes Medication				
Name of Medication	Time	Dosage	Route	Possible Side Effects
Authorizations				
HEALTH CARE PROVIDER AUTHORIZATION			PARENT/GUARDIAN AUTHORIZATION	
I authorize the administration of the medications and student diabetes self-management as ordered above.			By signing below, I authorize:	
			<ul style="list-style-type: none"> <li>• The designated school personnel to administer the medication and treatment orders as prescribed above.</li> </ul>	
<b>Provider Name (PRINT):</b>			By signing below, I agree to:	
<b>Phone:</b>			<ul style="list-style-type: none"> <li>• Provide the necessary diabetes management supplies and equipment; and</li> <li>• Notify the nurse of any changes in my child's care or condition.</li> </ul>	
<b>Fax:</b>				
<b>Provider Signature:</b>		<b>Date:</b>	<b>Parent Signature:</b>	
			<b>Date:</b>	
Acknowledged and received by:			School Nurse:	
			<b>Date:</b>	

**Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form**

Valid from: Start \_\_\_/\_\_\_/\_\_\_ to End \_\_\_/\_\_\_/\_\_\_ or for School Year \_\_\_\_\_

<b>Student Name:</b>	<b>DOB:</b>	<b>Grade:</b>
<b>Blood Glucose Monitoring*</b>		*Self-management skills to be verified by school nurse
<b>Blood Glucose (BG) Monitoring:</b>		
<input type="checkbox"/> Before meals <input type="checkbox"/> Before PE/Activity <input type="checkbox"/> After PE/Activity <input type="checkbox"/> Prior to dismissal <input type="checkbox"/> Additional monitoring per parent request <input type="checkbox"/> For symptoms of hypo/hyperglycemia & anytime the student does not feel well <input type="checkbox"/> <b>Student may independently check BG*</b>		
<b>Continuous Glucose Monitoring</b>		
<input type="checkbox"/> Uses CGM    Make/Model: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <b>Alarms set for:    Low _____ mg/dl    High _____ mg/dl    <input type="checkbox"/> If sensor falls out at school, notify parent</b>		
<b>Hypoglycemia Management*</b>		*Self-management skills to be verified by school nurse
<b>Mild or Moderate Hypoglycemia (BG _____ mg/dl to _____ mg/dl):</b>		
<input type="checkbox"/> <b>Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious &amp; able to swallow. If glucose gel is given, place student in recovery position.</b> <input type="checkbox"/> Suspend pump for BG < _____ mg/dl and restart pump when BG > _____ mg/dl <input type="checkbox"/> Student should consume a meal or snack within _____ minutes after treating hypoglycemia <input type="checkbox"/> Other: _____ <b>Always treat hypoglycemia before the administration of meal/snack insulin</b> <b>Repeat BG check 15 minutes after use of quick-acting glucose</b> <ul style="list-style-type: none"> <li>• If BG still low, re-treat with 15 gram quick-acting CHO as stated above</li> <li>• If BG in acceptable range and it is lunch or snack time, have student eat and cover meal CHO per orders</li> <li>• If CGM in use and BG 70 and arrow going up, no need to recheck</li> </ul> <b>Student may self-manage mild or moderate hypoglycemia and notify the school nurse*:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Severe Hypoglycemia (BG &lt; _____ mg/dl):</b>		
If symptoms worsen despite treatment/retreatment _____ times, student is unconscious, semi-conscious, unable to control his/her airway, unable to swallow or seizing give: <input type="checkbox"/> <b>GLUCAGON</b> injection: <input type="checkbox"/> 1 mg <input type="checkbox"/> 0.5 mg    IM or SQ <ul style="list-style-type: none"> <li>• Place student in the recovery position</li> <li>• Suspend pump, if applicable, and restart pump at BG &gt; _____ mg/dl</li> <li>• Call 911 and state glucagon was given for hypoglycemia; notify parent/guardian</li> </ul> <input type="checkbox"/> Use glucose gel inside cheek, even if unconscious, seizing if glucagon not available or there is no response to glucagon administration. <b>If glucose gel is given, place student in recovery position.</b>		
<b>Hyperglycemia Management*</b>		*Self-management skills to be verified by school nurse
<b>If BG greater than _____ mg/dl, or when child complains of nausea, vomiting, and/or abdominal pain, check urine/blood for ketones.</b>		
<ul style="list-style-type: none"> <li>• If urine ketones are <b>trace to small</b> or blood ketones _____ mmol/L:                             <ul style="list-style-type: none"> <li>• Give _____ ounces of sugar-free fluid or water per hour</li> <li>• Give insulin as listed in Insulin Orders</li> </ul> </li> <li>• If urine ketones are <b>moderate to large</b> or blood ketones greater than _____ mmol/L                             <ul style="list-style-type: none"> <li>• Give _____ ounces of sugar-free fluid or water</li> <li>• Give insulin as listed in Insulin Orders</li> </ul> </li> <li>• <b>If large ketones, vomiting or other signs of ketoacidosis, call 911.</b> Notify parent/guardian</li> <li>• Recheck BG and ketones _____ hours after administering insulin</li> <li>• Contact Parent/Guardian for:    <input type="checkbox"/> BG &gt; _____ mg/dl    <input type="checkbox"/> Ketones _____ mmol/L</li> </ul> <b>Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Snacks</b>		
Snacks needed: <input type="checkbox"/> Before physical education/physical activity/sports longer than _____ mins <input type="checkbox"/> Per parent/guardian <input type="checkbox"/> Per student <input type="checkbox"/> Limit snack to _____ grams of CHO <input type="checkbox"/> Delay snack if BG > _____ mg/dl <input type="checkbox"/> No snack coverage <input type="checkbox"/> Other: _____		

<b>Provider Name:</b>	<b>Signature:</b>	<b>Date:</b>
<b>Acknowledged and received by:</b>	<b>School Nurse:</b>	<b>Date:</b>

**Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form**

Valid from: Start \_\_\_/\_\_\_/\_\_\_ to End \_\_\_/\_\_\_/\_\_\_ or for School Year \_\_\_\_\_

<b>Student Name:</b>	<b>DOB:</b>	<b>Grade:</b>
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**Physical Education, Physical Activity, and Sports**

- Avoid physical education, physical activity, and sports if:     BG < \_\_\_ mg/dl     BG > \_\_\_ mg/dl     Ketones present
- If BG is 80-100 mg/dl, give 15 grams of CHO and return to physical education, physical activity, or sports
- May disconnect pump for sports activities
- Student may set temporary basal rate
- Other:

**Transportation**

- BG must be > \_\_\_ mg/dl for bus ride/walk home
- Only check BG if symptomatic prior to bus ride/walk home
- Allow student to carry quick-acting glucose for consumption on bus, as needed for hypoglycemia
- Student must be transported home with parent/guardian if (specify): \_\_\_\_\_
- Other:

**Disaster Plan (if needed for lockdown, 72 hr shelter in place)**

- Continue to follow orders contained in this medical management plan
- Additional insulin orders as follows:
- Other:

**Pump Management**

Type of Pump: \_\_\_\_\_ Pump start date: \_\_\_\_\_ Child Lock:     On     Off

Basal rates:    \_\_\_ unit(s)/hour    \_\_\_ AM/PM    \_\_\_ unit(s)/hour    \_\_\_ AM/PM  
                   \_\_\_ unit(s)/hour    \_\_\_ AM/PM    \_\_\_ unit(s)/hour    \_\_\_ AM/PM  
                   \_\_\_ unit(s)/hour    \_\_\_ AM/PM    \_\_\_ unit(s)/hour    \_\_\_ AM/PM

**Additional Hyperglycemia Management:**

- If BG > \_\_\_\_\_ mg/dl and has not decreased over \_\_\_\_\_ hours after bolus, consider infusion site change. Notify parent/guardian
- For infusion site failure:     Give insulin via syringe or pen     Change infusion site
- For suspected pump failure, suspend or remove pump and give insulin via syringe or pen
- If BG > \_\_\_ mg/dl and moderate to large ketones, student should change infusion site and give correction dose by pen or syringe
- Comments:

**Independent Pump Management Skills and Supervision needs\***  
\*Skills to be verified by school nurse. Supervision will be provided if not fully independent when appropriate

**Student is independent in the pump skills indicated below:**

- Carbohydrate counting                       Bolus an insulin dose                       Set a basal rate/temporary basal rate
- Reconnect pump at infusion set             Prepare and insert infusion set             Troubleshoot alarms and malfunctions
- Give self-injection if needed               Disconnect pump                               Other:

**Additional Orders**

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**Parent/Guardian Consent for Self-Management**

- I acknowledge that my child  **is**     **is not** authorized to self-manage as indicated by my child's health care provider.
- I understand the school nurse will work with my child to learn self-management skills he/she is not currently capable of or authorized to perform independently.

**My child has my permission to independently perform the diabetes tasks listed below as indicated by my child's health care provider:**

- Blood glucose monitoring                       Insulin administration                       Pump management
- Carbohydrate counting                         Insulin dose calculation                       Other:

<b>Parent/Guardian Name:</b>	<b>Signature:</b>	<b>Date:</b>
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<b>Provider Name:</b>	<b>Signature:</b>	<b>Date:</b>
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<b>Acknowledged and received by:</b>	<b>School Nurse:</b>	<b>Date:</b>
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