### Insulin Orders

**Carbohydrate Independent**
- Carbohydrate counting
- Syringe
- Pump (make/model):

#### Insulin Dosing:
- **Carbohydrate (CHO) Coverage per meal:**
- **Carbohydrate (CHO) Dose Adjustment Prior To Strenuous Exercise:**
- **Correction Dose:**
- **Fixed Dose Insulin:**
- **Split Insulin Dose:**

#### Snack Insulin Coverage:
- **Ketone Coverage:**

#### Insulin Dose Administration Principles

### Demographics

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Name</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian</td>
<td></td>
</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>Grade</td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
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</tr>
<tr>
<td>Home Phone</td>
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<tr>
<td>Work Phone</td>
<td></td>
</tr>
<tr>
<td>Cell Phone</td>
<td></td>
</tr>
</tbody>
</table>

### Insulin Dosing

- **Carbohydrate Independent**
- **Insulin Administration**

#### Insulin Dosing:
- **Carbohydrate Independent**
- **Insulin Dose Calculations**
- **Independent Administration Skills & Supervision Needs**

### Other Diabetes Medication

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Time</th>
<th>Dosage</th>
<th>Route</th>
<th>Possible Side Effects</th>
</tr>
</thead>
</table>

### Authorizations

#### HEALTH CARE PROVIDER AUTHORIZATION

I authorize the administration of the medications and student diabetes self-management as ordered above.

**Provider Name (PRINT):**

**Phone:**

**Fax:**

**Provider Signature:**

**Date:**

#### PARENT/GUARDIAN AUTHORIZATION

By signing below, I authorize:

- The designated school personnel to administer the medication and treatment orders as prescribed above.

**Phone:**

**Fax:**

**Parent Signature:**

**Date:**

Acknowledged and received by: **School Nurse:**

**Date:**

Diabetes Medical Management Plan/Health Care Provider Order Form July 2017
# Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ___/___/___ to End ___/___/___ or for School Year _________

## Student Name:
DOB: 
Grade: 

### Blood Glucose Monitoring*

*Self-management skills to be verified by school nurse

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Before meals</td>
<td>□ Before PE/Activity</td>
</tr>
<tr>
<td>□ Prior to dismissal</td>
<td>□ Additional monitoring per parent request</td>
</tr>
<tr>
<td>□ For symptoms of hypo/hyperglycemia &amp; anytime the student does not</td>
<td>□ Student may independently check BG*</td>
</tr>
<tr>
<td>feel well</td>
<td></td>
</tr>
<tr>
<td>□ Self-management skills to be verified by school nurse</td>
<td></td>
</tr>
</tbody>
</table>

### Continuous Glucose Monitoring

- Uses CGM
- Make/Model: Other:
- Alarms set for: Low _____ mg/dl High _____ mg/dl
- If sensor falls out at school, notify parent

### Hypoglycemia Management*

*Self-management skills to be verified by school nurse

#### Mild or Moderate Hypoglycemia (BG _____ mg/dl to _______ mg/dl):

- Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious & able to swallow.
- If glucose gel is given, place student in recovery position.
- Suspend pump for BG < _______ mg/dl and restart pump when BG > _______ mg/dl
- Student should consume a meal or snack within _____ minutes after treating hypoglycemia
- Other:

#### Always treat hypoglycemia before the administration of meal/snack insulin

Repeat BG check 15 minutes after use of quick-acting glucose

- If BG still low, re-treat with 15 gram quick-acting CHO as stated above
- If BG in acceptable range and it is lunch or snack time, have student eat and cover meal CHO per orders
- If CGM in use and BG 70 and arrow going up, no need to recheck

#### Severe Hypoglycemia (BG < ______mg/dl):

If symptoms worsen despite treatment/re-treatment ________ times, student is unconscious, semi-conscious, unable to control his/her airway, unable to swallow or seizing give:

- GLUCAGON injection: □ 1 mg □ 0.5 mg IM or SQ
  - Place student in the recovery position
  - Suspend pump, if applicable, and restart pump at BG > _____ mg/dl
  - Call 911 and state glucagon was given for hypoglycemia; notify parent/guardian

- Use glucose gel inside cheek, even if unconscious, seizing if glucagon not available or there is no response to glucagon administration.
- If glucose gel is given, place student in recovery position

#### Hyperglycemia Management*

*Self-management skills to be verified by school nurse

If BG greater than _____ mg/dl, or when child complains of nausea, vomiting, and/or abdominal pain, check urine/blood for ketones.

- If urine ketones are trace to small or blood ketones _____ mmol/L:
  - Give _____ ounces of sugar-free fluid or water per hour
  - Give insulin as listed in Insulin Orders
- If urine ketones are moderate to large or blood ketones greater than _____ mmol/L:
  - Give _____ ounces of sugar-free fluid or water
  - Give insulin as listed in Insulin Orders
- If large ketones, vomiting or other signs of ketoacidosis, call 911. Notify parent/guardian
- Recheck BG and ketones ________ hours after administering insulin
- Contact Parent/Guardian for: □ BG > _________mg/dl □ Ketones _________ mmol/L

#### Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse*: □ Yes □ No

### Snacks

- Snacks needed:
  - □ Before physical education/physical activity/sports longer than _____ mins
  - □ Per parent/guardian
  - □ Per student
  - □ Delay snack if BG > _______ mg/dl
  - □ No snack coverage
  - □ Other:

#### Provider Name: 
Signature: 
Date: 

Acknowledged and received by: 
School Nurse: 
Date: 

Diabetes Medical Management Plan/Health Care Provider Order Form July 2017
Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form
Valid from: Start ___/___/___ to End ___/___/___ or for School Year _________

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<th>Grade:</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Basal rates:</th>
<th>AM/PM</th>
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<th>AM/PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>____ unit(s)/hour</td>
<td>___ AM/PM</td>
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</table>

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

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:

Parent/Guardian Name: Signature: Date:

Provider Name: Signature: Date:

Acknowledged and received by: School Nurse: Date: