

STUDENT

First: _____

Last: _____

DOB: _____ Grade: _____

Emergency Contact Name: _____
(other than parent)

PARENT

Parent's Names: _____

Father Cell: _____

Mother Cell: _____

Emergency Contact Number: _____

TO BE COMPLETED BY PHYSICIAN

#1 - BLOOD SUGAR CHECKS

Target Blood Sugar Range _____ to _____.

Select one: ☐ Student can perform checks independently **OR**
☐ Requires school nurse assistance.

Check all that apply for times to check BG:

- ☐ Before lunch ☐ After snack ☐ As needed for signs of low or high blood sugar
☐ After lunch ☐ Before P.E.
☐ Before snack ☐ After P.E. ☐ Other: _____

☐ If checked, use Dexcom G6/G5 readings to dose insulin. If signs/symptoms do not match Dexcom readings, perform fingerstick blood sugar.

Glucosemeter Type/Brand: _____

Supplies/glucosemeter will be kept: ☐ In the health room
☐ With the student

#2 - INSULIN ADMINISTRATION

Insulin administered by: ☐ Pen ☐ Syringe ☐ Pump

Type of Insulin: ☐ Humalog
☐ Novolog
☐ Regular
☐ Other: _____

Meals and snacks: _____ Units for every _____ grams of carbohydrates eaten

Correction Dose? ☐ No
☐ Yes, please select one of the following:
☐ _____ Units for every _____ mg/dl points above _____ mg/dl
☐ BOLUS per pump recommendations

#3 - HYPOGLYCEMIA - BLOOD SUGAR LESS THAN _____ MG/DL

Symptoms of hypoglycemia: dizziness, shaking, anxiety, hunger, blurry vision, weakness/fatigue, headache, behavior changes, pallor, loss of consciousness, seizure.

This student may also exhibit: _____

If student presents with symptoms check BG. If BG level is below _____, treat with _____ grams of fast acting sugar (glucose tabs, juice or snack provided by health room.) Recheck BG in 15 minutes, treat again until BG is greater than _____.

SEVERE HYPOGLYCEMIA: BG BELOW _____. Indications for use of Glucagon: unconsciousness, drowsy, inability to swallow by mouth.
Administer GLUCAGON: _____ mg/IM/SQ/Intranasal. **CALL 911 and notify parent.**

#4 - HYPERGLYCEMIA - BLOOD SUGAR GREATER THAN _____ MG/DL

Symptoms of hyperglycemia: increased thirst, frequent urination, hunger, fatigue, irritability, double vision, nausea/vomiting, abdominal pain.

This student may also exhibit: _____

If student presents with symptoms check BG. If BG level is over _____ mg/DL and it has been greater than _____ hours since the last insulin dose.

- Give insulin per sliding scale/BOLUS per pump recommendations.
- Give 8 - 16 oz of water per hour.
- Recheck BG in two hours and treat with sliding scale insulin as needed.
- When having symptoms of nausea/vomiting, student will be released from school to parent/guardian.

Check ketones if BG is over _____ mg/DL for _____ hours. If ketones are present notify the parent/guardian.

When student has insulin pump: • Blood sugar greater than 300 mg/DL with ketones or two consecutive unexplained blood sugars greater than 300 mg/DL (with or without ketones), may indicate a malfunction in the pump.
• Student may require insulin via injection and/or new infusion site. **PARENTS MUST BE NOTIFIED.**

→ PHYSICIAN SIGNATURE: _____ DATE: _____
PHYSICIAN NAME PRINTED: _____ PHONE: _____

TO BE COMPLETED BY PARENT/GUARDIAN

#5 - STUDENT SELF-CARE

Please select all that apply:

- ☐ Totally independent management ☐ Self-injects with verification of dose ☐ Self-injects with trained staff supervision
☐ Test blood sugar independently ☐ Self-injects mild hypoglycemia ☐ Injections to be done by trained staff
☐ Tests and interprets urine/blood ketones ☐ Monitors own snacks and meals
☐ Administers insulin independently ☐ Independently counts carbohydrates

I authorize the Diabetes Care Team to notify me via the following methods: ☐ Voicemail or text at cell phone: _____
☐ E-mail at: _____

→ PARENT SIGNATURE: _____ DATE: _____

ALL MEDICATION WILL BE DISCARDED IF NOT PICKED UP BY MAY 27, 2022.
THE ABOVE MEDICATION ORDER IS VALID FOR ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.