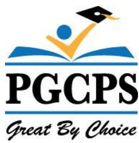


Prince George's County Public Schools
Office of School Health policy, Services, and Innovation

Management of Diabetes at School/Order Form

Student:______________________________ **DIABETES TYPE:** ❒ Type One ❒ Type Two

Blood Glucose Monitoring:
Target range for blood glucose monitoring at school:______________________
❒ Before Snacks ❒ 2 hours after lunch ❒ As needed for symptoms of hypo/hyperglycemia
❒ Before meals ❒ 2 hours after a correction dose ❒ With signs and symptoms of illness
❒ Other times:______________________________

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 9ll, 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: ______________________________

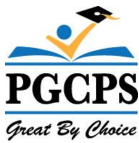
Disaster Plan (if needed for lockdown, 24 hr shelter in place):
❒ Follow insulin orders as on Management Form
❒ Administer insulin as follows: ______________________________
❒ Administer long acting insulin as follows: ______________________________
❒ Other: ______________________________

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
Office of School Health policy, Services, and Innovation

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:

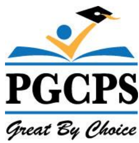
1. To provide the necessary supplies and equipment.
2. To notify the school nurse if there is a change in the student's diabetes management or health care provider.

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 ______________



Prince George's County Public Schools
Office of School Health policy, Services, and Innovation

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: __________ 12amto__________ __________ 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: ____________