Attachment 6 to A.P. 5163

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 (accompanied by “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
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   - Blood Glucose from ________ to ________ / Units

   - [ ] Calculated Insulin dose (add correction dose and carbohydrate coverage for total insulin dose):
     Coverage: ________ # 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 ____________
Parent/Guardian Signature ____________ Date ____________

Order reviewed by School Nurse (per local policy): ____________ Date ____________
### Management of Diabetes at School

**Blood Glucose Monitoring:**
- **Target range for blood glucose monitoring at school:**
  - Before Snacks
  - 2 hours after lunch
  - Before meals
  - 2 hours after a correction dose
  - As needed for symptoms of hypo/hyperglycemia
  - 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 911, notify parent
  - Glucagon injection (1 mg in 1 cc) ______________mg, 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:

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**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)

<table>
<thead>
<tr>
<th>Student:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
</tr>
</tbody>
</table>

**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?  
  - □ yes □ no  
- 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/carctridges, 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:  

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