Lander County School District

Licensed Health Care Provider's Diabetes Orders

Student's Name:_____ **DOB:**_____

❑ **This student is authorized to FUNTION INDEPENDENTLY in his/her Diabetes management.**

In the event that school nurse intervention may be required please provide the following information:

Name of treatments or procedures:

❑ Blood Glucose Monitoring
❑ Insulin type:_____
❑ Insulin Administration via: ❑ Pen ❑ Pump ❑ Injection
❑ Ketone testing

While at school, blood glucose monitoring is to be done:

❑ Before lunch ❑ before PE ❑ when symptomatic ❑ other (please specify)

_____

Snacks:

❑ Give daily snack at the following times_____ _____ _____ _____
❑ No routine daily snacks required at school.

***Hypoglycemia:**

If blood sugar is less than _____ (or symptomatic): Give_____
Recheck blood sugar in 10-15 minutes.
If **still** less than_____: Give_____
Recheck blood sugar in 10-15 minutes:
If next scheduled meal is greater than 30" Give_____
If acting seriously ill, call 911.
Call parent/guardian to pick up child

Individual considerations:_____

***Hyperglycemia:**	**Individual Considerations:**
If blood sugar is greater than_____:	_____
Check urine for ketones.	_____
Encourage non-caloric fluids (water, diet drinks).	_____
If ketones "negative or trace":	_____
Recheck blood sugar in 2-3 hours.	_____
If ketones "moderate or large":	_____
Contact parent/guardian to pick child up from school	_____
Encourage parent/guardian to call doctor	_____

Individual Considerations:_____

Correction Factor: _____ units of insulin for every _____ points blood sugar > _____
Carbohydrate Ratio: _____ units of insulin for every _____ grams of carbs to be eaten
Base Unit/Other:_____

❑ **Parent may make adjustment to daily insulin dosage, correction factor and carb ratio.**

*****Parent is responsible for informing school nurse of any changes.

Name of Health Care Provider (please print)_____ **Phone:**_____
Signature of Health Care Provider:_____ **Date:**_____
I am in agreement with the orders set forth by the physician as stated above:
Parent Signature:_____ Date:_____
School Nurse Signature:_____ Date:_____

Lander County School District

Diabetes Adjustment Sheet

Student Name_____ DOB_____

Date	Insulin to Carb Ratio	Correction Factor	Person Authorizing	Nurse Signature