

Demographics				
Student Name:		DOB:	Grade:	Diagnosis:
Parent/Guardian:		Home Phone:	Work Phone:	Cell Phone:
Insulin Orders				
Insulin Dosing:				
☐ Carbohydrate coverage	☐ Correction dose only	☐ Correction dose plus CHO coverage	☐ Fixed dose	☐ Fixed dose with correction scale ☐ See attached dosing scale
Insulin(s):				
☐ Rapid Acting: ☐ Apidra ☐ Humalog ☐ Novolog ☐ Admelog ☐ Other (specify): _____ ☐ Any of the rapid acting insulins may be substituted for the others				
☐ Long Acting (if given at school): _____ Give _____ unit(s) of insulin Sub-Q at _____ (time)				
Insulin Delivery: ☐ Pen ☐ Syringe ☐ Pump (make/model): _____				
Carbohydrate (CHO) Coverage per meal: ☐ _____ unit(s) of insulin Sub-Q per _____ grams of CHO at breakfast				
☐ _____ unit(s) of insulin Sub-Q per _____ grams of CHO at lunch ☐ _____ unit(s) of insulin Sub-Q per _____ grams of CHO at dinner				
Carbohydrate Dose Adjustment Prior To Strenuous Exercise Within _____ Minutes:				
☐ Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at breakfast ☐ Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at lunch ☐ Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at dinner				
Correction Dose: ☐ Give _____ unit(s) of insulin Sub-Q for every _____ mg/dl greater than BG of _____ mg/dl				
☐ If pre-breakfast BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose ☐ If pre-lunch BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose ☐ If pre-dinner BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose				
☐ Fixed Dose Insulin: _____ unit(s) of insulin Sub-Q given before school meals				
☐ Split Insulin Dose: Give _____ unit(s) or _____% of meal insulin dose Sub-Q before meal and _____ unit(s) or _____% of meal insulin dose Sub-Q after meal				
Snack Insulin Coverage: ☐ No snack coverage ☐ Snack coverage if BG > _____ mg/dl				
☐ _____ unit(s) of insulin Sub-Q per _____ grams of CHO				
Insulin Dose Administration Principles				* See page 2 for Hyperglycemia management
Insulin should be given:				
☐ Before meals ☐ Before snacks ☐ Other times (please specify): _____ ☐ For correction if BG > _____ mg/dl and _____ hours since last dose/bolus ☐ If CHO intake cannot be predetermined, insulin should be given no more than _____ minutes after start of meal/snack ☐ If parent/guardian requests, insulin should be given no more than _____ minutes after start of meal/snack				
☐ Use pump or bolus device calculations per programmed settings, once settings have been verified				
☐ Parent/Guardian has permission to increase/decrease insulin correction dose by +/- one (1) unit to three (3) units of insulin or adjust the CHO ratio by +/- 20 grams of CHO per one (1) unit of insulin				
Independent Insulin Administration Skills & Supervision Needs*				*Skills to be verified by school nurse
☐ Insulin dose calculations ☐ Independent ☐ With Supervision		☐ Carbohydrate counting ☐ Independent ☐ With Supervision		☐ Measuring insulin ☐ Independent ☐ With Supervision
				☐ Insulin administration ☐ Independent ☐ With Supervision
Other Diabetes Medication				
Name of Medication	Time	Dosage	Route	Possible Side Effects
Authorizations				
HEALTH CARE PROVIDER AUTHORIZATION			PARENT/GUARDIAN AUTHORIZATION	
I authorize the administration of the medications and student diabetes self-management as ordered above.			By signing below, I authorize:	
Provider Name (PRINT):			• The designated school personnel to administer the medication and treatment orders as prescribed above.	
			By signing below, I agree to:	
Phone:			• Provide the necessary diabetes management supplies and equipment; and	
			• Notify the nurse of any changes in my child's care or condition.	
Provider Signature:			Parent/Guardian Signature:	Date:
Date:				
Acknowledged and received by:			School Nurse:	Date:

Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ____/____/____ **to End** ____/____/____ **or for School Year** _____

Student Name: _____		DOB: _____		
Blood Glucose Monitoring*		*Self-management skills to be verified by school nurse		
Blood Glucose (BG) Monitoring: ☐ Before meals ☐ Before PE/Activity ☐ After PE/Activity ☐ Prior to dismissal ☐ Additional monitoring per parent/guardian request ☐ For symptoms of hypo/hyperglycemia & anytime the student does not feel well ☐ Student may independently check BG*				
Continuous Glucose Monitoring				
☐ Uses CGM Make/Model: _____ Is this CGM make/model approved by the FDA for insulin dosing? ☐ Yes ☐ No Alarms set for: Low _____ mg/dl High _____ mg/dl ☐ If sensor falls out at school, notify parent/guardian				
Hypoglycemia Management*		*Self-management skills to be verified by school nurse		
Mild or Moderate Hypoglycemia (BG below _____ mg/dl) ☐ Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious & able to swallow. ☐ 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 grams 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 mg/dL and arrow going up, no need to recheck Student may self-manage mild or moderate hypoglycemia and notify the school nurse*: ☐ Yes ☐ No Severe Hypoglycemia (includes any of the following symptoms): • Unconsciousness • Semi-consciousness • Inability to control airway • Inability to swallow • Seizing • Worsening of symptoms despite treatment/retreatment as above ☐ GLUCAGON injection: ☐ 1 mg ☐ 0.5 mg IM or Sub-Q • 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 ☐ If glucagon is not available or there is no response to glucagon, administer glucose gel inside cheek, even if unconscious or seizing. If glucose gel is administered, 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 as tolerated • Give insulin as listed in insulin orders no more than every _____ hour(s) If urine ketones are moderate to large or blood ketones greater than _____ mmol/L: • Give _____ ounces of sugar-free fluid or water per hour as tolerated • If student uses pump, disconnect pump • Give insulin as listed in insulin orders no more than every _____ hour(s) by injection If large ketones and vomiting or large ketones and 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				
Ketone Coverage				
<table border="0" style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> For ketones trace to small (urine)/< _____ mmol/L (blood) ☐ Correction dose plus _____ unit(s) of insulin ☐ _____ unit(s) of insulin </td> <td style="width:50%; vertical-align: top;"> For ketones moderate to large (urine)/> _____ mmol/L (blood) ☐ Correction dose plus _____ unit(s) of insulin ☐ _____ unit(s) of insulin </td> </tr> </table>			For ketones trace to small (urine)/< _____ mmol/L (blood) ☐ Correction dose plus _____ unit(s) of insulin ☐ _____ unit(s) of insulin	For ketones moderate to large (urine)/> _____ mmol/L (blood) ☐ Correction dose plus _____ unit(s) of insulin ☐ _____ unit(s) of insulin
For ketones trace to small (urine)/< _____ mmol/L (blood) ☐ Correction dose plus _____ unit(s) of insulin ☐ _____ unit(s) of insulin	For ketones moderate to large (urine)/> _____ mmol/L (blood) ☐ Correction dose plus _____ unit(s) of insulin ☐ _____ unit(s) of insulin			
Parent/Guardian Name: _____	Signature: _____	Date: _____		
Provider Name: _____	Signature: _____	Date: _____		

Acknowledged and received by: _____	School Nurse: _____	Date: _____
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Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ____/____/____ to End ____/____/____ or for School Year _____

Student Name: _____		DOB: _____	
Physical Education, Physical Activity, and Sports			
Self-management skills to be verified by school nurse ☐ Avoid physical education/physical activity/sports if: ☐ BG < ____ mg/dl ☐ Trace/small ketones present ☐ BG > ____ mg/dl ☐ Moderate/large ketones present ☐ If BG is ≤ ____ mg/dl, give 15 grams of CHO and return to physical education/physical activity/sports ☐ May disconnect pump for physical education/physical activity/ sports ☐ Student may set temporary basal rate for physical education/physical activity/sports ☐ Other: _____			
Transportation			
Self-management skills to be verified by school nurse ☐ Check BG prior to dismissal ☐ If BG is not > ____ mg/dl, give ____ grams carbohydrate snack ☐ 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 Basal rates: _____ unit(s)/hour _____ AM/PM _____ unit(s)/hour _____ AM/PM _____ unit(s)/hour _____ AM/PM _____ unit(s)/hour _____ AM/PM _____ unit(s)/hour _____ AM/PM _____ unit(s)/hour _____ AM/PM 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 <u>moderate to large</u> 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			
☐ Please FAX copies of BG/insulin diabetes management records every ____ weeks (FAX number: _____) ☐ Other 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 ☐ Carbohydrate counting ☐ Insulin administration ☐ Insulin dose calculation ☐ Pump management ☐ Other: _____			
Parent/Guardian Name: _____		Signature: _____	
Provider Name: _____		Signature: _____	
Acknowledged and received by: _____		School Nurse: _____	
		Date: _____	