Diabetes Information/Orders from Physician

For Students Without Pump

Physician please complete and have parent bring on or prior to the first day of school

Date_____

Student Name _____ **DOB** _____**School** _____

Physician:_____ **Office Phone:**_____

Diabetes Educator: _____**Pager:**_____ **Phone:**_____

Diagnosis:_____

I. General Orders

A. Blood Glucose Goal Range _____ to _____mg/dl
Call parents if student's blood sugar:
is below_____
above _____
urine ketones present _____

B. Times for glucose testing at school _____
at home _____

C. Current Insulin orders or see attached sheet_____
_____

D. Other medications: _____

E. Meal/snack planned:_____

F. Check blood glucose prior to physical activities? _____yes _____no

G. Special instructions regarding physical activity on field trips, track day, etc.
Check if appropriate:
- Blood Sugar testing _____
- Snack _____
- When to exclude from activity _____

H. Level of Diabetic Self Care approved by physician/provider:

Student Alone	Student with Supervision	Student Requires Assistance	
_____	_____	_____	Perform own blood sugar checks
_____	_____	_____	Count carbohydrates
_____	_____	_____	Determine correct amount of insulin
_____	_____	_____	Draw correct amount of insulin
_____	_____	_____	Give own injections
_____	_____	_____	Check urine ketones

I. Student has been instructed regarding:
Yes/No Signs and symptoms in recognizing hypoglycemia and hyperglycemia
Yes/No Universal precautions
Yes/No Proper disposal of sharps

II. Emergency Orders for _____ Hypoglycemia and _____Hyperglycemia

Check one:

_____ Use standard attached treatment plan as attached
Physician's Hyperglycemia Treatment Plan
Physician's Hypoglycemia Treatment Plan

_____ See attached MD orders

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III. Signatures and Authorizations

A. **Physician**:
These orders as noted previously and as noted on the Hypoglycemic Treatment Plan and the Hyperglycemic Treatment Plan will be in effect for the school year.

_____ _____
Physician Signature **Date**

B. **Parent/Guardian Authorization:**

1. Release of Medical Information from Physician
I authorize _____ to fax/phone diabetes related information this school
Doctor's Office

year regarding my child _____, who attends _____
Child's Name
school to the school clinic.

_____ _____ _____
Parent/Guardian Signature **Print Name** **Date**

2. Consent to communicate with physician
I give permission for LISD Student Health Services to communicate with my child's doctor's office concerning my child's diabetes.

_____ _____ _____
Parent/Guardian Signature **Print Name** **Date**

C. **School Nurse/Clinical Manager**:
I have reviewed the order for safe implementation. The date for renewal/review is _____.

_____ _____
School Nurse/Clinical Manager **Date**

D. **School Principal**:
I have accepted the order to be carried out by the school nurse/trained personnel in my school.

_____ _____
School Principal Signature **Date**