Diabetes Information/Orders from Physician

For Students With Pump

Physician please complete and have parent bring on or prior to the first day student attends 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____
   - Food/Meal Correction Bolus: ________units of insulin for every ________ grams of carbohydrate.
   - Correction Factor Bolus for hyperglycemia: ________ units of insulin for every ________mg/dl over _____mg/dl.

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. Student Pump Skill Competency

A. It is recommended that students under the age of 10 years old should be supervised and assisted by a trained adult when making any Insulin Pump adjustments, according to their skills.
B. Students 10 years and older should exhibit competent pump skills, as stated below, in order to self-administer Insulin Pump.
C. If pump malfunctions (Blood sugar > 250mg/dl x2) or tubing becomes dislodged, call parent/guardian immediately.

- Infusion set changes will only be done by parent/guardian.
- If there are any pump problems/malfunctions/questions, call the parent/guardian.
- If unable to reach the parent or parent is unable to troubleshoot successfully, call physician or the help line on the pump.

PUMP SKILLS OF STUDENT (complete on ALL students)	ASSISTANCE NEEDED?	
Counts carbohydrates	Yes	No
Give bolus for carbohydrates eaten	Yes	No
Calculates and gives correction bolus	Yes	No
Set a temporary basal rate	Yes	No
Disconnect pump if needed/reconnects pump	Yes	No
Infusion set change	Yes	No
Give injection with syringe	Yes	No
Troubleshoots all alarms	Yes	No

D. Person to provide procedures: _____ School Nurse ______Trained School Staff
_____ Student _____ Student with assistance/supervision

IV. Signatures and Authorizations

A. **Physician**:
These orders as noted previously 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 from Physician:**

1. **Release of Medical Information**

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 clinic.

________________________________ ________________________ ___________________

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

2. **Consent to communicate with physician and consent for Treatment**
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**

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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**