HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN

STUDENT WITH DIABETES ON INSULIN **INJECTIONS** (MONTANA FORM VERSION 8/21/15)

EFFECTIVE DATE:	End Date:
STUDENT'S NAME:	Date of Birth:

DIABETES HEALTHCARE PROVIDER INFORMATION Name:

Phone #: Fax #: Email:

SCHOOL: School Fax:

⇨**See accompanying Algorithm for Blood Glucose Results as supplement to these orders*****

Monitor Blood Glucose: ☒ Check as needed for signs and symptoms of low or high blood glucose, or does not feel well.

Before lunch Other:______________________________

Before PE Other:______________________________

Before leaving school Other:______________________________

Where to check: ☐ Anywhere Classroom ☐ Health office ☐ Other: ______________

Insulin: ☐ *Humalog/NovoLog/Apidra* ☐ *Other:* ______________________________

Insulin Delivery: ☐ Syringe/vial ☐ Pen

Carbohydrate Coverage:

Breakfast: Give 1 unit for _______ grams of carbohydrate **OR** ☐ Standard daily insulin injection (please describe):

AM Snack: Give 1 unit for _______ grams of carbohydrate ______________________________

Lunch: Give 1 unit for _______ grams of carbohydrate ______________________________

PM Snack: Give 1 unit for _______ grams of carbohydrate ______________________________

☐ **Correction scale:** **OR** ☐ **Correction Formula**:

BG Range: ____________ Give________ units

BG Range: ____________ Give ________ units

BG Range: ____________ Give________ units

BG Range: ____________ Give ________ units

BG Range: ____________ Give________ units

BG Range: ____________ Give ________ units

Give ______ units of insulin for every __________ mg/dl of blood glucose above target blood glucose of ________________mg/dl.

Formula used to calculate correction:

Blood glucose ______ minus(-) target blood glucose _______ = ________.

Then divide (÷) by correction factor (__________) = **_______________.**

☐ Give Correction Scale Before Lunch Only ☐ Other: ______________________________

Do not give insulin correction dose more than once every 3 hours to prevent "stacking" insulin.

Check ketones if nausea, vomiting or abdominal pain OR if blood glucose >300 twice when checked 2-3 hours apart.

- ☐ Use correction scale **OR** ☐ Use correction scale plus an additional ______ units for moderate and ______ units for large.
- Repeat ketone check in 2 hours, and repeat additional insulin if moderate or large ketones are still present.

Exercise and Sports: ☐ Student should monitor blood glucose hourly ☐ Other:______________________

Parent/Guardian Authority: To adjust insulin dose: ☐ Yes ☐ No

To change frequency of blood glucose monitoring: ☐ Yes ☐ No

Diabetes Medications:

☐ **Glucagon (for emergency low blood glucose) -** Dose: ☐ 0.5 mg ☐ 1.0 mg Given IM or SC per thigh or arm

☐ Medication: ____________________ Dose: _______________ Times to be given: _______________

☐ Medication: ____________________ Dose: _______________ Times to be given: _______________

HCP Assessment of Student's Diabetes Management Skills:

Skill	Independent	Needs supervision	Cannot do
Check blood glucose			
Count carbohydrates			
Calculate insulin dose			
Injection			

☐ Student may advance in independence through school year if school/parent agrees.

Notes:

HEALTHCARE PROVIDER SIGNATURE/STAMP:	Date:
Parent/Guardian Signature:	Date:

UPDATES TO THE
HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN
STUDENT WITH DIABETES ON INSULIN **INJECTIONS**

STUDENT'S NAME:	Date of Birth:
DIABETES HEALTHCARE PROVIDER INFORMATION Name: Phone #: Fax #: Email:	
SCHOOL:	School Fax:

Effective Date: **Update:**

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	