

Demographics					
Student Name:	DOB:	Grade:	Diagnosis:		
Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:		
Insulin Orders					
Insulin Dosing:					
<input type="checkbox"/> Carbohydrate coverage	<input type="checkbox"/> Correction dose only	<input type="checkbox"/> Correction dose plus CHO coverage	<input type="checkbox"/> Fixed dose	<input type="checkbox"/> Fixed dose with correction scale	<input type="checkbox"/> See attached dosing scale
Insulin(s):					
<input type="checkbox"/> Rapid Acting:	<input type="checkbox"/> Apidra	<input type="checkbox"/> Humalog	<input type="checkbox"/> Novolog	<input type="checkbox"/> Admelog	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Any of the rapid acting insulins may be substituted for the others					
<input type="checkbox"/> Long Acting (if given at school): _____ Give _____ unit(s) of insulin Sub-Q at _____ (time)					
Insulin Delivery: <input type="checkbox"/> Pen <input type="checkbox"/> Syringe <input type="checkbox"/> Pump (make/model): _____					
Carbohydrate (CHO) Coverage per meal: <input type="checkbox"/> _____ unit(s) of insulin Sub-Q per _____ grams of CHO at breakfast					
<input type="checkbox"/> _____ unit(s) of insulin Sub-Q per _____ grams of CHO at lunch <input type="checkbox"/> _____ unit(s) of insulin Sub-Q per _____ grams of CHO at dinner					
Carbohydrate Dose Adjustment Prior To Strenuous Exercise Within _____ Minutes:					
<input type="checkbox"/> Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at breakfast					
<input type="checkbox"/> Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at lunch					
<input type="checkbox"/> Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at dinner					
Correction Dose: <input type="checkbox"/> Give _____ unit(s) of insulin Sub-Q for every _____ mg/dl greater than BG of _____ mg/dl					
<input type="checkbox"/> If pre-breakfast BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose					
<input type="checkbox"/> If pre-lunch BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose					
<input type="checkbox"/> If pre-dinner BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose					
<input type="checkbox"/> Fixed Dose Insulin: _____ unit(s) of insulin Sub-Q given before school meals					
<input type="checkbox"/> 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: <input type="checkbox"/> No snack coverage <input type="checkbox"/> Snack coverage if BG > _____ mg/dl					
<input type="checkbox"/> _____ unit(s) of insulin Sub-Q per _____ grams of CHO					
Insulin Dose Administration Principles				* See page 2 for Hyperglycemia management	
Insulin should be given:					
<input type="checkbox"/> Before meals <input type="checkbox"/> Before snacks <input type="checkbox"/> Other times (please specify): _____					
<input type="checkbox"/> For correction if BG > _____ mg/dl and _____ hours since last dose/bolus					
<input type="checkbox"/> If CHO intake cannot be predetermined, insulin should be given no more than _____ minutes after start of meal/snack					
<input type="checkbox"/> If parent/guardian requests, insulin should be given no more than _____ minutes after start of meal/snack					
<input type="checkbox"/> Use pump or bolus device calculations per programmed settings, once settings have been verified					
<input type="checkbox"/> Parent/Guardian has permission to increase/decrease insulin correction dose by +/- one (1) unit to three (3) units					
Independent Insulin Administration Skills & Supervision Needs*				*Skills to be verified by school nurse	
<input type="checkbox"/> Insulin dose calculations	<input type="checkbox"/> Carbohydrate counting	<input type="checkbox"/> Measuring insulin	<input type="checkbox"/> Insulin administration		
<input type="checkbox"/> Independent <input type="checkbox"/> With Supervision	<input type="checkbox"/> Independent <input type="checkbox"/> With Supervision	<input type="checkbox"/> Independent <input type="checkbox"/> With Supervision	<input type="checkbox"/> Independent <input type="checkbox"/> 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.		
Phone:			By signing below, I agree to:		
Fax:			• Provide the necessary diabetes management supplies and equipment; and		
Provider Signature:			• Notify the nurse of any changes in my child's care or condition.		
Date:			Parent/Guardian Signature:	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:		
<input type="checkbox"/> Before meals <input type="checkbox"/> Before PE/Activity <input type="checkbox"/> After PE/Activity <input type="checkbox"/> Prior to dismissal <input type="checkbox"/> Additional monitoring per parent/guardian request <input type="checkbox"/> For symptoms of hypo/hyperglycemia & anytime the student does not feel well <input type="checkbox"/> Student may independently check BG*		
Continuous Glucose Monitoring		
<input type="checkbox"/> Uses CGM Make/Model: _____ Alarms set for: Low _____ mg/dl High _____ mg/dl <input type="checkbox"/> 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)		
<input type="checkbox"/> Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious & able to swallow. <input type="checkbox"/> Suspend pump for BG < _____ mg/dl and restart pump when BG > _____ mg/dl <input type="checkbox"/> Student should consume a meal or snack within _____ minutes after treating hypoglycemia <input type="checkbox"/> Other: _____		
Always treat hypoglycemia before the administration of meal/snack insulin		
Repeat BG check 15 minutes after use of quick-acting glucose		
<ul style="list-style-type: none"> • 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*: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Severe Hypoglycemia (includes any of the following symptoms):		
<ul style="list-style-type: none"> • Unconsciousness • Inability to swallow • Semi-consciousness • Seizing • Inability to control airway • Worsening of symptoms despite treatment/retreatment as above 		
<input type="checkbox"/> GLUCAGON injection: <input type="checkbox"/> 1 mg <input type="checkbox"/> 0.5 mg IM or Sub-Q <ul style="list-style-type: none"> • 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 		
<input type="checkbox"/> 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:		
<ul style="list-style-type: none"> • 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		
<ul style="list-style-type: none"> • 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: <input type="checkbox"/> BG > _____ mg/dl <input type="checkbox"/> Ketones _____ mmol/L		
Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse*: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Ketone Coverage		
For ketones trace to small (urine)/< _____ mmol/L (blood) For ketones moderate to large (urine)/> _____ mmol/L (blood)		
<input type="checkbox"/> Correction dose plus _____ unit(s) of insulin <input type="checkbox"/> Correction dose plus _____ unit(s) of insulin <input type="checkbox"/> _____ unit(s) of insulin <input type="checkbox"/> _____ 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			
<small>*Self-management skills to be verified by school nurse</small>			
<input type="checkbox"/> Avoid physical education/physical activity/sports if: <input type="checkbox"/> BG < ___ mg/dl <input type="checkbox"/> BG > ___ mg/dl <input type="checkbox"/> Trace/small ketones present <input type="checkbox"/> Moderate/large ketones present <input type="checkbox"/> If BG is ≤ _____ mg/dl, give 15 grams of CHO and return to physical education/physical activity/sports <input type="checkbox"/> May disconnect pump for physical education/physical activity/ sports <input type="checkbox"/> Student may set temporary basal rate for physical education/physical activity/sports* <input type="checkbox"/> Other:			
Transportation			
<small>*Self-management skills to be verified by school nurse</small>			
<input type="checkbox"/> Check BG prior to dismissal <input type="checkbox"/> If BG is not > _____ mg/dl, give _____ grams carbohydrate snack <input type="checkbox"/> BG must be > _____ mg/dl for bus ride/walk home <input type="checkbox"/> Only check BG if symptomatic prior to bus ride/walk home <input type="checkbox"/> Allow student to carry quick-acting glucose for consumption on bus, as needed for hypoglycemia* <input type="checkbox"/> Student must be transported home with parent/guardian if (specify): _____ <input type="checkbox"/> Other:			
Disaster Plan (if needed for lockdown, 72 hr shelter in place)			
<input type="checkbox"/> Continue to follow orders contained in this medical management plan <input type="checkbox"/> Additional insulin orders as follows: <input type="checkbox"/> Other:			
Pump Management			
Type of Pump:	Pump start date:	Child Lock: <input type="checkbox"/> On <input type="checkbox"/> 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:			
<input type="checkbox"/> If BG > _____ mg/dl and has not decreased over _____ hours after bolus, consider infusion site change. Notify parent/guardian <input type="checkbox"/> For infusion site failure: <input type="checkbox"/> Give insulin via syringe or pen <input type="checkbox"/> Change infusion site <input type="checkbox"/> For suspected pump failure, suspend or remove pump and give insulin via syringe or pen <input type="checkbox"/> If BG > ___ mg/dl and <u>moderate to large</u> ketones, student should change infusion site and give correction dose by pen or syringe <input type="checkbox"/> Comments:			
Independent Pump Management Skills and Supervision Needs*			
<small>*Skills to be verified by school nurse. Supervision will be provided if not fully independent when appropriate</small>			
Student is independent in the pump skills indicated below:			
<input type="checkbox"/> Carbohydrate counting	<input type="checkbox"/> Bolus an insulin dose	<input type="checkbox"/> Set a basal rate/temporary basal rate	
<input type="checkbox"/> Reconnect pump at infusion set	<input type="checkbox"/> Prepare and insert infusion set	<input type="checkbox"/> Troubleshoot alarms and malfunctions	
<input type="checkbox"/> Give self-injection if needed	<input type="checkbox"/> Disconnect pump	<input type="checkbox"/> Other:	
Additional Orders			
<input type="checkbox"/> Please FAX copies of BG/insulin diabetes management records every _____ weeks (FAX number: _____) <input type="checkbox"/> Other orders:			
Parent/Guardian Consent for Self-Management			
<input type="checkbox"/> I acknowledge that my child <input type="checkbox"/> is <input type="checkbox"/> is not authorized to self-manage as indicated by my child's health care provider. <input type="checkbox"/> 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:			
<input type="checkbox"/> Blood glucose monitoring	<input type="checkbox"/> Insulin administration	<input type="checkbox"/> Pump management	
<input type="checkbox"/> Carbohydrate counting	<input type="checkbox"/> Insulin dose calculation	<input type="checkbox"/> Other:	
Parent/Guardian Name:	Signature:	Date:	
Provider Name:	Signature:	Date:	
Acknowledged and received by:	School Nurse:	Date:	