### Insulin Orders

#### Insulin Dosing:
- **Carbohydrate (CHO) Coverage per meal:**
  - __unit(s) of insulin SQ per gram of CHO at breakfast
  - __unit(s) of insulin SQ per gram of CHO at lunch

#### Carbohydrate Dose Adjustment Prior To Strenuous Exercise:
- Use exercise/PE ratio of ___ unit(s) of insulin per ___ grams of CHO at breakfast
- Use exercise/PE ratio of ___ unit(s) of insulin per ___ grams of CHO at lunch

#### Correction Dose:
- Give ___ unit(s) of insulin for every ___ mg/dl greater than target BG of _____ mg/dl
- If pre-meal BG less than ___ mg/dl, subtract ___ unit(s) of insulin dose

#### Fixed Dose Insulin:
- Give ___ unit(s) of insulin SQ per ___ grams of CHO before meals

#### Split Insulin Dose:
- Give ___ unit(s) or ___% of meal insulin dose SQ before meal and ___ unit(s) or ___% of meal insulin dose SQ after meal

#### Snack Insulin Coverage:
- __unit(s) of insulin SQ per gram of CHO in snack
- __unit(s) of insulin SQ for snack greater than ___ grams of CHO

### Ketone Coverage

#### For ketones trace to small (urine)/<____ mmol/L (blood)
- Correction dose plus ___ unit(s) of insulin

#### For ketones moderate to large (urine)/>____ mmol/L (blood)
- Correction dose plus ___ unit(s) of insulin

### Insulin Dose Administration Principles

- Insulin should be given:
  - Before meals
  - Before snacks
  - Other times (please specify):
    - For hyperglycemia 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 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 has permission to increase/decrease insulin correction dose by +/- ___ unit(s) or by ratio ___ unit(s) to ____ mg/dl
  - Parent has permission to increase/decrease CHO coverage by +/- ___ unit(s) of insulin or by ratio of ___ unit(s) to ___ grams of CHO

### Independent Insulin Administration Skills & Supervision Needs*

- **Insulin dose calculations**
  - Independent
  - With Supervision
- **Carbohydrate counting**
  - Independent
  - With Supervision
- **Measuring insulin**
  - Independent
  - With Supervision
- **Insulin administration**
  - Independent
  - With Supervision

### Other Diabetes Medication

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Time</th>
<th>Dosage</th>
<th>Route</th>
<th>Possible Side Effects</th>
</tr>
</thead>
</table>

### Authorizations

#### HEALTH CARE PROVIDER AUTHORIZATION

I authorize the administration of the medications and student diabetes self-management as ordered above.

**Provider Name (PRINT):**

**Phone:**

**Fax:**

**Provider Signature:**

**Date:**

#### PARENT/GUARDIAN AUTHORIZATION

By signing below, I authorize:

- **The designated school personnel to administer the medication and treatment orders as prescribed above.**
- **Provide the necessary diabetes management supplies and equipment; and**
- **Notify the nurse of any changes in my child's care or condition.**

**Phone:**

**Fax:**

**Affiliated: **

**Provider Signature:**

**Date:**

**School Nurse:**

**Date:**

Acknowledged and received by:

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Diabetes Medical Management Plan/Health Care Provider Order Form July 2017

Page 1 of 3
Maryland Diabetes Medical Management Plan/Health Care Provider Order Form

Valid from: Start ___/___/___ to End ___/___/___ or for School Year _________

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>DOB:</th>
<th>Grade:</th>
</tr>
</thead>
</table>

### Blood Glucose (BG) Monitoring
- **Blood Glucose Monitoring**: *Self-management skills to be verified by school nurse*
  - [ ] Before meals
  - [ ] Before PE/Activity
  - [ ] After PE/Activity
  - [ ] Prior to dismissal
  - [ ] Additional monitoring per parent 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: _____
- [ ] Other: _____
- Alarms set for:
  - Low _____ mg/dl
  - High _____ mg/dl
  - [ ] If sensor falls out at school, notify parent

### Hypoglycemia Management
- **Mild or Moderate Hypoglycemia (BG _____ mg/dl to _____ 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

### Severe Hypoglycemia (BG < _____ mg/dl):
- If symptoms worsen despite treatment/re-treatment ________ times, student is unconscious, semi-conscious, unable to control his/her airway, unable to swallow or seizing give:
  - [ ] GLUCAGON injection:
    - [ ] 1 mg
    - [ ] 0.5 mg
    - IM or SQ
  - 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 glucose gel is given, place student in recovery position.

### Hyperglycemia Management
- **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
      - Give insulin as listed in Insulin Orders
    - [ ] If urine ketones are moderate to large or blood ketones greater than ______ mmol/L:
      - Give _____ ounces of sugar-free fluid or water
      - Give insulin as listed in Insulin Orders
    - [ ] If large ketones, vomiting or 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

### Snacks
- Snacks needed:
  - [ ] Before physical education/physical activity/sports longer than ______ mins
  - [ ] Per parent/guardian
  - [ ] Per student
  - [ ] Limit snack to _____ grams of CHO
  - [ ] Delay snack if BG > _______ mg/dl
  - [ ] No snack coverage
  - [ ] Other:

**Provider Name:**

**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 _________

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<th>Grade:</th>
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</table>

**Physical Education, Physical Activity, and Sports**
- □ Avoid physical education, physical activity, and sports if:  
  - □ BG < _____ mg/dl  
  - □ BG > _____ mg/dl  
  - □ Ketones present
- □ If BG is 80-100 mg/dl, give 15 grams of CHO and return to physical education, physical activity, or sports
- □ May disconnect pump for sports activities
- □ Student may set temporary basal rate
- □ Other:  

**Transportation**
- □ 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**

<table>
<thead>
<tr>
<th>Type of Pump:</th>
<th>Pump start date:</th>
<th>Child Lock:</th>
<th>□ On □ Off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basal rates:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ unit(s)/hour ___ AM/PM</td>
<td>___ unit(s)/hour ___ AM/PM</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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 moderate to large ketones, student should change infusion site and give correction dose by pen or syringe
- □ Other:

**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**

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**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
- □ Insulin administration
- □ Pump management
- □ Carbohydrate counting
- □ Insulin dose calculation
- □ Other:

<table>
<thead>
<tr>
<th>Parent/Guardian Name:</th>
<th>Signature:</th>
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