Health Care Provider Orders for Student with Diabetes on Insulin Pump

To be completed by the Health Care Provider and used in conjunction with the Standards of Care for Diabetes Management in the School Setting
www.coloradokidswithdiabetes.org

Student:	DOB:	School:	Grade:
Physician/Provider:		Phone:	
Diabetes Educator:		Phone:	

TARGET RANGE – Blood Glucose:	**mg/dl TO mg/dl**			
☐< 5y.o. 80-200mg/dl	☐ 5 – 8 y.o 80-200mg/dl	☐ 9-11y.o 70-180mg/dl	☐ 12-18y.o. 70-150mg/dl	☐ >18y.o. 70-130mg/dl
Notification to Parents: Low < *target range* and High > 300 mg/dl or ***Other:***	less than____ **mg/dl** and	greater than:____ **mg/dl**		
☐ Continuous glucose monitoring: Always *Confirm glucose level with a fingerstick/meter prior to treatment unless student has a Dexcom G5 or G6, it may be used for dosing and treatment. Please follow* ***Collaborative*** **Guidelines for Dexcom G5 & G6: Therapeutic Dosing in the School Setting (www.coloradokidswithdiabetes.org)**				

Hypoglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here:

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For *Severe Symptoms:* Call 911, Disconnect Pump, Administer: ☐**Glucagon Injection Dose:** **mg Intramuscular in**
OR ☐BAQSIMI nasal spray 1 device (3mg) in one nostril

Hyperglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here:

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Ketone Testing: *per Standards of Care for Diabetes Management in the School Setting – Colorado* OR Other:	

When to Check Blood Glucose: *For provision of student safety while limiting disruption to learning*
✔**Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns**
✔**Check before meals and as mutually agreed upon by parent and school nurse**
☐ **Other:**

Insulin Pump: *Follow Guidelines for Insulin Administration by School Staff, Diabetes Resource Nurses February 2013*

- Pump settings are established by the student's healthcare provider and should not be changed by the school staff. All setting changes to be made at home or by student providing self care as indicated on IHP.
- Internal safety features for the insulin pump should be active at all times while the student is at school - (Alarms set conservatively).

Insulin Pump Brand: ____	Type of Insulin in pump____
Correction Bolus: Provide Correction bolus per pump calculator. All BG levels should be entered into the pump for administration of pump-calculated corrections unless otherwise indicated on the provider orders.	
☐**Sensitivity/Correction Factor:**	_____ unit insulin for every _____mg/dl above target BG range starting at _____**mg/dl**
☐ **Insulin**Dosing Attached	
☐ If blood glucose is ***less than ___ mg/dl,*** wait to give meal bolus until after meal	
When Hyperglycemia occurs other than at lunchtime: ☐ If it has been greater than **3 hours** since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders **if approved by the school nurse and parent is notified.** ☐ **Cont**act Health Care Provider for One-time order	

Carbohydrates and Insulin Dosage per pump: ☐ **Breakfast** ☐**Snack** ☐**Lunch** ☐**Other:** ☐ **Insulin** Dosing Attached

Insulin to Carbohydrate Ratio: _____**unit(s)** for every _____ **grams** of carbohydrate to be eaten

Bolus for carbohydrates should occur immediately ☐ Prior to lunch/snack ☐**A**fter lunch/snack ☐ Split ½ before lunch & ½ after lunch ☐ Other: ____

☐ Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

Pump Malfunctions: Disconnect pump when malfunctioning

If pump calculator is operational then the insulin dosing should be calculated by using the pump bolus calculator and then insulin given by injection

If pump calculator is not operational: ☐ School Nurse or Parent to give insulin according to Insulin to Carbohydrate Ratio and/or Correction Factor
☐ Call Parent and Health Care Provider (for orders)

Student's Self Care: ☐No supervision ☐Full supervision, ☐Requires some supervision: ability level to be determined by school nurse and parent unless otherwise indicated here:

Additional Information:

Signatures: My signature below provides authorization for the written orders above and exchange of health information to assist the school nurse an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is for a maximum of one year.

Physician: _____ Date: _____

Parent: _____ Date: _____

School Nurse: _____ Date: _____