Maryland State Management of Diabetes at School/Order Form
This order is valid only for the Current School Year: ______ (including summer session)

Student: ____________________________ DOB: ____________________________
School: ____________________________ Grade: ____________________________

CONTACT INFORMATION
Parent/Guardian: ____________________________ Home Phone: ____________ Work: ____________ Cell/pager: ____________
Parent/Guardian: ____________________________ Home Phone: ____________ Work: ____________ Cell/pager: ____________

Other Emergency Contact: __________________________________________________________

Insulin Orders (complete only if insulin is needed at school):
1. Insulin administration via:
   - Syringe and vial
   - Insulin pen
   - Insulin pump
   - Other
   Type of pump: ____________________________ Basal rates: ____________________________

2. Insulin Before Lunch/Meals:
   - Routine lunchtime dose: ____________________________
   - Per sliding scale as follows:
     - Meals:
       - Blood Glucose ________ to ________ give ________ units
       - Blood Glucose ________ to ________ give ________ units
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   - Calculated insulin dose (add carbohydrate coverage and correction dose for total insulin dose):
     - Carbohydrate Coverage: Insulin to carbohydrate ratio
     - Give ________ # units insulin per ________ gms carbohydrate.
     - Correction:
       - Give ________ # unit(s) insulin per ________ mg/dl of glucose above ________ mg/dl
       - Subtract ________ # units for every ________ mg/dl of glucose below ________ mg/dl

3. Other times insulin may be given:
   - Snack: ________ ________ units
   - Ketones:
     - If ketones are ________ ________ units
     - If ketones are ________ ________ units

Health Care Provider Authorization for Management of Diabetes in School
My signature below provides authorization for the above written orders. This authorization is for a maximum of one school year. If changes are indicated, I will provide new written authorization, which may be faxed.

Health Care Provider Name: ____________________________ Signature: ____________________________ (original or stamped signature) *Sign both sides.
Address: ____________________________ City: ____________________________ Zip: ____________
Phone: ____________________________ Fax: ____________________________ Date: ____________

Parent Consent for Management of Diabetes at School
I (We) request designated school personnel to administer the medication and treatment orders as prescribed above. I agree
1. To provide the necessary supplies and equipment
2. To notify the school nurse if there is a change in the student’s diabetes management or health care provider.
I authorize the school nurse to communicate with the health care provider as necessary.

Parent/Guardian Signature: ____________________________ Date: ____________ *Sign both sides.
Other Emergency Contact: _____________________________________________________________________ Date: ____________

Order reviewed and signed by School Nurse (per local policy): Date: ____________

DOB: ____________________________ School: ____________________________
Student: ____________________________
Grade: ____________________________

Phone: ____________________________ Fax: ____________________________ Date: ____________
Maryland State Management of Diabetes at School/Order Form

**Student:**

**Blood Glucose Monitoring:**

<table>
<thead>
<tr>
<th>Target range for blood glucose monitoring at school:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Before snacks</td>
</tr>
<tr>
<td>☐ Before meals</td>
</tr>
<tr>
<td>☐ As needed for symptoms of hypo/hyperglycemia</td>
</tr>
<tr>
<td>☐ With signs and symptoms of illness</td>
</tr>
<tr>
<td>☐ Other times: ____________________________________________________________</td>
</tr>
</tbody>
</table>

**Hypoglycemia – blood glucose less than ______**

<table>
<thead>
<tr>
<th>Self treatment for mild lows.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Give ______ grams of fast-acting carbohydrate according to care plan. Recheck BG in 10-15 mins. Repeat treatment if BG less than ___ mg/dl</td>
</tr>
<tr>
<td>☐ Provide extra protein &amp; carbohydrate snack after treating low if next meal/snack greater than ____ minutes away</td>
</tr>
<tr>
<td>☐ Suspend pump for severe hypoglycemia for _____ mins.</td>
</tr>
</tbody>
</table>

- If student is unconscious, having a seizure or unable to swallow, presume student is having a low blood sugar and:
  - Call 911, notify parent
  - ☐ Glucagon injection (1 mg in 1 cc) ______ mg, subcutaneously or intramuscular (IM)
  - ☐ OK to use glucose gel inside cheek, even if unconscious, seizing.
  - ☐ Other: ____________________________________________________________

**Hyperglycemia – blood glucose greater than ______**

| Check urine ketones, follow care plan, administer insulin as per orders. |
| For pumps, insulin may be given by syringe or pen if needed. |
| Encourage sugar free fluids, at least _____ ounces per ______. |
| If student complains of nausea, vomiting or abdominal pain; check urine ketones & check insulin administration orders. |
| ☐ Other: ____________________________________________________________

* Transport to local Emergency Room may be needed with vomiting and large ketones.

**Meal Plan**

| ☐ AM snack, time: ________ | ☐ PM snack time: ________ | ☐ Avoid snack if blood glucose greater than ______ mg/dl. |
| ☐ Lunch: ____________________ | ☐ Extra food allowed; ☐ Parent’s discretion; ☐ Student’s discretion |

**Exercise (check and/or complete all that apply)**

Fast-acting carbohydrate source must be available before, during and after all exercise.

| ☐ With student | ☐ With teacher |
| If most recent blood glucose is less than ______, exercise can occur when blood glucose is corrected and above ______. |
| ☐ Eat _____ grams of carbohydrate | ☐ Before Every 30 mins during | ☐ After vigorous exercise |
| ☐ Avoid exercise when blood glucose is greater than ______ or ketones are ______. |

**Bus Transportation**

| ☐ Blood glucose monitoring not required prior to boarding bus |
| ☐ Check blood glucose 15 minutes prior to boarding bus |
| ☐ Allow student to eat on bus if having symptoms of low blood glucose |
| ☐ Provide care as follows: ________________________________________________ |

**Health Care Provider Assessment**

Student can self-perform the following procedures (school nurse and parent must verify competency):

| ☐ Blood glucose monitoring | ☐ Measuring insulin | ☐ Injecting insulin | ☐ Determining insulin dose |
| ☐ Independently operating insulin pump |
| ☐ Other: ____________________________________________________________ |

**Disaster Plan** (if needed for lockdown, 24 hr shelter in place):

| ☐ Follow insulin orders as on Management Form |
| ☐ Additional insulin orders as follows: __________________________________________ |
| ☐ Administer long acting insulin as follows: ______________________________________ |
| ☐ Other: ____________________________________________________________ |

**Other instructions:**

______________________________________________________________________________

| Health Care Providers Signature: ___________________ | Phone: ___________ | Date: ____________ |
| Parent’s Signature: ________________________________ | Phone: ___________ | Date: ____________ |

Order reviewed by School Nurse (per local policy): ___________________ | Date: ____________ |
Maryland State Supplemental Form for Students with Insulin Pumps
This order is valid only for the Current School Year:______ (including summer session)

Student: ______________________________             DOB: ___________________
School: _______________________________             Grade: __________

CONTACT INFORMATION:
Parent/Guardian: _____________________  Home Phone: __________  Work: __________  Cell/pager: ___________
Parent/Guardian: _____________________  Home Phone: __________  Work: __________  Cell/pager: ___________
Pump Resource Person: ______________________  Phone: ______________________________
Other Emergency Contact: __________________________________

Pump Management
Type of pump: _______________________  Start Date for Pump Therapy: __________________________
Type of Insulin in pump: _________________________
Basal rates: ____________  12am to ____________  Comment: _____________________
__________    _______   ___________
__________    _______   ___________
__________    _______   ___________
__________    _______   ___________
Insulin/carbohydrate ratio: ____________  Check Management of Diabetes at School Order or correction factor
Hyperglycemia:  
___ Pump site should be changed if BG greater than _____________ times _______________
___ Insulin should be given by syringe or pen if needed _______________________________

Management Skills of Student
• As verified by school nurse, health care provider and parent
  Independent?
  Count carbohydrates  __ yes  __ no
  Calculate an insulin dose  __ yes  __ no
  Bolus an insulin dose  __ yes  __ no
  Reset basal rate profiles  __ yes  __ no
  Set a temporary basal rate  __ yes  __ no
  Disconnect pump  __ yes  __ no
  Reconnect pump at infusion set  __ yes  __ no
  Prepare infusion set for insertion  __ yes  __ no
  Insert infusion set  __ yes  __ no
  Troubleshoot alarms and malfunctions  __ yes  __ no
  Give self injection if needed  __ yes  __ no
  Change batteries  __ yes  __ no

  __ Student is non-independent  Child Lock On?  Yes  No

Pump Supplies
Extra supplies needed include: Infusion sets, reservoir/cartridges, insertion device, insulin vial & syringes, batteries
Location of supplies: _________________________________________________________________________

Disaster Plan (If needed for lockdown, etc):
□ Follow Insulin orders as on Management Form
□ Insulin doses as follows: _____________________________
Other: ___________________________________________________________________________________

Health Care Provider's Signature: ______________________________   Date: ________________

Parent's Signature: ______________________________________            Date: ________________

Order reviewed by School Nurse (per local policy):    Date: ________________