MONTOURSVILLE AREA SCHOOL DISTRICT

INDIVIDUAL STUDENT

# DIABETES Physician Orders

Dear Parent/Guardian:

 You have told us that your child has diabetes. Please have your child’s physician complete the order sheet below and return to the nurse. To help your child, please let us know of any changes in your child’s diabetes or medication schedule.

 Thank you,

 School Nurse

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Physician treating child’s diabetes: Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. For **Hypoglycemia** (blood sugar less than \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ grams of carbohydrates

1. For **Severe hypoglycemia** (cannot be treated by mouth)

Give \_\_\_\_\_\_\_\_\_\_\_ mg of glucagon by intramuscular injection

1. Give Humalog/Novolog Insulin as follows via insulin pump or subcutaneous injection (circle what route applies).

All meals and snacks except those used to treat low blood sugars are to be covered with \_\_\_\_\_\_\_ units of Humalog/Novolog Insulin for every \_\_\_\_\_\_\_\_\_grams of carbohydrates.

All high readings are to be covered with:

 \_\_\_\_\_\_ units for every \_\_\_\_\_\_\_\_ points above \_\_\_\_\_\_\_\_

1. For ketones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. This high blood sugar scale may be used every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours as needed.

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Physician’s Signature Date

*Must be completed each school year.*

MONTOURSVILLE AREA SCHOOL DISTRICT

HEALTH SERVICE MUTUAL AGREEMENT:

Student Independent Performance of Blood Glucose Monitoring and Insulin Administration

School Year \_\_\_\_-\_\_\_\_

Student ‘s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_

This agreement has been established in order to maintain student safety, well-being, and autonomy.

The **student** will:

* Independently perform blood glucose monitoring and insulin administration as ordered by Healthcare Provider.
* Maintain a written record of blood glucose results and insulin doses while at school and show it to the school nurse weekly, for her evaluation (times may change if deemed necessary).
* Seek help from school nurse if any problems with their diabetes should occur.
* Treat hypoglycemia per written doctor’s order and will go to the nurse’s office for further evaluation.
* Self-administer appropriate insulin dose based on the written orders from his/her Health Care Provider.
* Not allow anyone else to use his/her medication or supplies.
* Follow Standard Precautions (change lancet device at home, dispose of needle and syringe in a designated sharps container).
* Adhere to the guidelines established. Failure to demonstrate safe independent glucose monitoring and insulin administration including but not limited to abuse, misuse, or non-compliance, will result in the student reporting to the nurse’s office to perform blood glucose testing and insulin administration.

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 Student’s Signature Date

The **parent** will:

* Provide the necessary equipment such as: blood glucose testing supplies, juice, snacks, glucose products, syringes, pump supplies and insulin.
* Will notify (within one school day) the school nurse, in writing, of any changes in the student’s health status, insulin orders, medication changes or treatment.
* Reinforce with the student the responsibilities associated with independent care regarding his/her diabetes.

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 Parent/Guardian’s Signature Date

The **school nurse** will:

* Evaluate blood glucose monitoring and insulin records and discuss with the student and/or parent/guardian any concerns regarding interventions or agreement compliance.
* Inform the student’s Healthcare Provider and/or parent/guardian of any unusual circumstances or findings.
* Will notify the parent/guardian when supplies or insulin are running low.
* Will inform the student’s teachers of signs and symptoms of hypo and hyperglycemia.
* Will obtain a copy of the blood glucose monitoring and insulin administration log from the student and place in his/her permanent School Health Record.
* Administer insulin or glucagon if student is unable to do so per student’s Healthcare provider’s order.

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 School Nurse’s Signature Date

*This agreement must be completed each school year, however, if non-compliance or a change in status occurs, any party may call for an immediate review.*