Washoe County School District
STUDENT HEALTH SERVICES
(Fax 775-353-5968)

LICENSED HEALTH CARE PROVIDER DIABETES ORDERS

THIS ORDER EXPIRES AT THE END OF THE SCHOOL YEAR

Date: _____

STUDENT NAME: _____ **DOB:** _____

SCHOOL: _____

PART I

Diabetes Mellitus ☐ **Type I** ☐ **Type II**

☐ This student is **NOT** independent in self-managing all aspects of his/her diabetes care. I authorize the school nurse, in collaboration with the parent/guardian, to determine the level of supervision and/or assistance required by the student for each of the following diabetes orders.

PART II

Specific Insulin Information:

ROUTINE (Meal time) Insulin ☐ No ☐ Yes If yes, complete the following information:
Insulin Type _____

Oral Medication ☐ No ☐ Yes If yes, attach "Consent and Request for Medication during School Hours," HEA-F205

HOME insulin information: _____

Insulin Injection via Syringe or Insulin Pen: ☐ No ☐ Yes If Yes, complete the following information:

Base Unit(s) ☐ No ☐ Yes If yes, please indicate number of routine base units to be given: _____

1) ROUTINE Blood Glucose Correction: ___ unit insulin for every ____ points blood glucose >____ mg/dl

2) ROUTINE Insulin-to Carbohydrate Coverage:

Breakfast Insulin-to-Carbohydrate Coverage ____ unit insulin for every _____ grams carbohydrates

Lunch Insulin-to-Carbohydrate Coverage ___ unit insulin for every _____ grams carbohydrates

Dinner Insulin-to-Carbohydrate Coverage _____ unit insulin for every _____ grams carbohydrates

3) NON-ROUTINE Insulin-to-Carbohydrate Coverage: ___ unit insulin for every _____ grams carbohydrates

☐ Subtract _____ unit if _____

Individual Orders:

_____

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Nutrition and Monitoring:

Snacks:

☐ Daily snacks ☐ AM (before lunch) _____ ☐ PM (after lunch) _____

Individual Orders: _____

Blood Glucose Testing:

☒ When symptomatic (required)

☒ Before insulin administration (required)

☒ Before breakfast/lunch diabetes care (required)

☐ Daily at Dismissal

☐ Additional Glucose Testing as Follows: _____

Ketone Testing:

☒ If blood glucose > 300 mg/dl check ketones:

☐ Urine ☐ Blood

Individual Orders: _____

PART III

LOW BLOOD GLUCOSE ORDERS:

• If blood glucose is < 75 OR _____ (alternative value must be >75mg/dl) or **student has symptoms:**

☒ Immediately give 15 to 30 grams of **fast-acting** carbohydrate

☒ RECHECK blood glucose 15 minutes after carbohydrate consumed

☒ If blood glucose is still < 75, give an additional 15 to 30 grams fast-acting carbohydrate, RECHECK blood glucose 15 minutes after carbohydrate consumed

☐ After blood glucose increases to ≥ 75, student will consume fat **and** protein snack or lunch, and then resume regular school activities.

Individual Orders:

_____

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NON-ROUTNE HIGH BLOOD GLUCOSE ORDERS:

If blood glucose is >300 mg/dl OR _____ alternative value (must be < 300mg/dl)

- Check ketones; if urine ketones < moderate, or blood ketones < 0.6, give 12-24 oz. water, and restrict vigorous exercise
- Hold insulin until next blood glucose recheck
- Recheck blood glucose and ketones in 2 hours

☐ If glucometer reads **HI** on two consecutive BG checks, administer _____ units of insulin, provided it has been 3 to 4 hours since student's last insulin dose AND parent/guardian is en route, AND student is asymptomatic.
☐ Per programed pump orders and parent/guardian is en route, AND student is asymptomatic.

PART IV

EMERGENCY INTERVENTIONS: 911 will be activated if:

☒ Student has moderate to severe symptoms AND has a high blood glucose level AND large urine ketones, or blood ketones > 1.5

☒ Parent/guardian not available for immediate pick up

☒ Student semi-conscious, unconscious or unable to swallow; school personnel to withhold fast-acting carb, begin standard emergency procedures, and activate school's code blue plan

☐ Administer glucose gel or other dissolvable fast-acting carbohydrate while 911 en route, provided student is conscious, sitting upright

PART V

Insulin Infusion via Insulin Pump: ☐ No ☐ Yes If Yes, complete the following information:

Pump Type: _____ Individual Pump Orders: _____

Pump is pre-programmed to deliver bolus insulin doses according to the following prescribed information.

☒ Insulin to be administered via injection per orders below in the event pump malfunctions.

1) ROUTINE Blood Glucose Correction: ___ unit insulin for every ____ points blood glucose > ____ mg/dl

☐ Insulin dosing for non-routine high blood glucose may be administered PRN at any time, according to the dosage indicated on the pump

2) ROUTINE Insulin-to Carbohydrate Coverage:

Breakfast Insulin-to-Carbohydrate Coverage ____ unit insulin for every ____ grams carbohydrates

Lunch Insulin-to-Carbohydrate Coverage _____ unit insulin for every ____ grams carbohydrates

Dinner Insulin-to-Carbohydrate Coverage ____ unit insulin for every ____ grams carbohydrates

3) NON-ROUTINE Insulin-to-Carbohydrate Coverage: ____ unit insulin for every ____ grams carbohydrates

Individual Orders:

_____

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Part VI

Continuous Blood Glucose Monitor: ☐ No ☐ Yes If Yes, complete the following information:

Monitor Type: _____User alarm set for Low _____High _____

☒ Blood Glucose Check: <75 or >300. When symptomatic.

Individual orders: _____

☒ Parents/guardian have signed separate consent for use of Continuous Blood Glucose Monitor

Part VII

Field Trip and afterschool activities:

Student may attend field trip/afterschool activity ☐ No ☐ Yes If yes, complete the following information:

☐ Continue above orders without additions.
☐ Continue above orders with the following addition(s): _____

Overnight Field trip additions
☐ Additional Diabetic Management orders dinner_____

☐ Additional Diabetic Management orders during the night _____

Consent and Request for Diabetes Care and Medication Assistance during School Hours:

The undersigned parent/legal guardian hereby requests the Washoe County School District ("District" or "WCSD") to assist and supervise the above named student in some or all aspects of his or her diabetes care the administration of the above described medication, as set forth, and consents to such assistance and supervision while the student is present on a WCSD campus, during WCSD transportation, and while participating in school-sponsored activities.

In addition, the undersigned parent/legal guardian hereby gives permission to the school nurse at the above described school to exchange confidential information, if needed, regarding the student's diabetes care and/or medication, with the undersigned health care provider or physician; and further hereby agrees to assume all risk and responsibility regarding the student's diabetes care or medication and to defend and hold the Washoe County School District, the Board of Trustees of the District, and all agents of the District harmless from any and all losses or liability, claims, and expenses, including any and all claims for contribution or indemnity by any party for their participation in assisting and supervising the above named student in diabetes care, including administration of medication.

The undersigned parent/legal guardian hereby agrees to provide the above named student with all diabetes medication, supplies, and equipment required to provide the student with the above diabetes care, including medication administration, while the student is present on a WCSD campus, during WCSD transportation, and while participating in school-sponsored activities and the undersigned parent or guardian agrees to assume all responsibility for maintaining the supply of the medication, supplies, and equipment and replacing such medication when its effectiveness has lapsed by reason of time. Medications that are kept in the school health office may not be sent home with students. Medications not claimed or picked up by the parent/guardian or their designee by the day following the last day of the school year will be disposed of by the school nurse or her designee.

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WCSD Carbohydrate/ School Menu Information:

Carbohydrate calculations are based on the most current menus provided by Washoe County School District Nutrition Services Department. Food substitutions and other variables could alter the student's carbohydrate ratio and the insulin dosage administered.

Note: Medications that are kept in the school health office may not be sent home with students. Medications not claimed or picked up by the parent/guardian or his/her designee by the day following the last day of the school year will be disposed of by the school nurse or his/her designee.

I am in agreement with the orders set forth as stated above:

Parent/Guardian Name (please print)_____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Health Care Provider Name (please print) _____

PHONE _____ FAX _____

Health Care Provider Signature: _____Date: _____

School Nurse Name/Title (please print) _____

School Nurse Signature: _____ Date: _____