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: _____

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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 _____

Insulin pump Type of pump: Basal rates:

2. Insulin Before Lunch/Meals: Name of Insulin: _____

Routine lunchtime dose: _____

Per sliding scale as follows:

Meals

Blood Glucoseto	_____	_____	give _____ units
Blood Glucoseto	_____	_____	_____
Blood Glucoseto	_____	_____	_____
Blood Glucoseto	_____	_____	_____
Blood Glucoseto	_____	_____	_____
Blood	_____	_____	Glucoseto _____
give	_____	_____	units Blood
Glucoseto	_____	_____	give _____ units
Blood Glucoseto	_____	_____	give _____ units
Blood Glucoseto			give _____ units
Blood Glucoseto	_____	_____	give _____ units
Blood Glucoseto	_____	_____	give _____ units
Blood Glucoseto	_____	_____	give _____ units
Blood Glucoseto	_____	_____	

Calculated insulin dose (add carbohydrate coverage and correction dose for total insulin dose):

Carbohydrate Coverage: Insulin to carbohydrate ratio Give _____ # unit(s) 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

Insulin may be given after lunch if: _____

3. Other times insulin may be given:

Snack: Dose: _____ Calculated as above. Snack: Blood Glucose Give: _____ units

Ketones: If ketones are _____ Give/Add: _____ unit(s) _____ units

If ketones are _____ Give/Add: _____ unit(s) _____ units

_____ 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:** _____

Use for Prescriber's Address Stamp

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.**

_____ Date _____

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