## HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN

STUDENT WITH DIABETES ON INSULIN **INJECTIONS** (Montana Form version 3/23/15)

EFFECTIVE DATE:	End Date:		
STUDENT'S NAME:	Date of Birth:		
DIABETES HEALTHCARE PROVIDER INFORMATION Name:			
Phone #: Fax #:	Email:		
School:	School Fax:		
⇒See accompanying Algorithm for Blood Glucose Results as	supplement to these orders***		
Monitor Blood Glucose: ⊠ Check as needed for signs and symptoms of low or high blood glucose, or does not feel well.			
Before lunch Other:			
Where to check: Anywhere Classroom Health office			
Insulin: ☐ Humalog/NovoLog/Apidra ☐ Other:			
Insulin Delivery:   Syringe/vial   Pen			
Carbohydrate Coverage:			
Breakfast: Give 1 unit for grams of carbohydrate <b>OR</b> Standard daily insulin injection (please describe):			
AM Snack: Give 1 unit for grams of carbohydrate			
Lunch: Give 1 unit for grams of carbohydrate			
PM Snack: Give 1 unit for grams of carbohydrate			
☐ Correction scale: OR ☐ Correction Formula:			
BG Range: Give units Give units of insuling	n for every mg/dl of blood glucose		
•	ofmg/dl.		
BG Range: Give units			
BG Range: Give units Formula used to calculate Give units Rland always a grain			
	us(-) target blood glucose =  on factor () =		
be range are units			
Give Correction Scale Before Lunch Only			
Do not give insulin correction dose more than once every 3 hours to prevent "stacking" insulin.  Check ketones if nausea, vomiting or abdominal pain OR if blood glucose >300 twice when checked 2-3 hours apart.			
• ☐ Use correction scale <b>OR</b> ☐ Use correction scale plus an additional units for moderate and units for large.			
• Repeat ketone check in 2 hours, and repeat additional insulin if moderate or large ketones are still present.			
Exercise and Sports: Student should monitor blood glucose hourly Other:			
Parent/Guardian Authority: To adjust insulin dose: Yes No			
To change frequency of blood glucose n	nonitoring: Yes No		
Diabetes Medications:			
☐ Glucagon (for emergency low blood glucose) - Dose: ☐ 0.5 mg ☐ Medication: Dose:	Times to be given:		
Medication: Dose:	Times to be given:		
HCP Assessment of Student's Diabetes Management Skills:	Notes:		
Skill Independent Needs supervision Cannot do			
Check blood glucose	<u> </u>		
Count carbohydrates Calculate insulin dose			
Injection			
☐ Student may advance in independence through school year if school/parent agrees.			
HEALTHCARE PROVIDER	Date:		
SIGNATURE/STAMP: Parent/Guardian			
	Date:		
Signature:			

## **UPDATES** TO THE

## HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN

STUDENT WITH DIABETES ON INSULIN **INJECTIONS** 

STUDENT'S	S NAME:	Date of Birth:	
DIABETES HEALTHCARE PROVIDER INFORMATION Name:  Phone #: Email:			
SCHOOL:			
Effective Date:	Update:		
Healthcare P	rovider signature:		
Parent/Guardian signature:			
Healthcare Provider signature:			
Parent/Guardian signature:			
Healthcare Provider signature:			
Parent/Guard	lian signature:		
	rovider signature:		
Parent/Guardian signature:			
Healthcare Provider signature:			
Parent/Guardian signature:			

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