*** Emergency names/phone numbers are on Processing Day Sheet, please keep us updated of any changes ***

Diabetes Orders

Place Child's Photo Here

Student's Name_____ **DOB**_____
School_____
Physician_____ **Effective Date**_____

Type of insulin: (circle one) Rapid or Short Acting: Apidra/Humalog/Novolog/Regular
Intermediate or Long-acting given at home: (cirlce one) NPH/Lantus/Levemir
Insulin to carbohydrate ratio (I:CR):_____**units/**_____**grams or Fixed insulin lunch dose**_____
Parent may adjust I:CR by +/- 1 to 5 grams Yes/No (circle one)
Correction Factor (CF) (insulin sensitivity**): CF:** _____ **units per** _____**mg/dl over** _____ **mg/dl**
(Correction Factor Formula: Student's BG minus Target BG ÷ correction factor = insulin dose)

Usual Insulin Dose Range_____. **Target blood glucose range:** 70-110 pre-meal. **Other:**_____

Insulin Pump: (if applicable)
Type: _____
Basal Rates: Time: Rate (units per hr)
12:00 am =_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Blood Glucose Monitoring (in classroom if possible) or Location_____

Before am snack _____
Before lunch ___X_____
Before exercise _____
After exercise _____
Signs of low or high blood sugar ____X_____
Other _____

Child is able to:
(Circle all that apply)
Test own glucose Yes/No
Determine insulin dose Yes/No
Draw up insulin Yes/No
Administer insulin dose Yes/No
Manage/troubleshoot pump Yes/No

Exercise and Sports
Student **should not** exercise if blood glucose is
BG is below _____mg/dl or
above _____mg/dl
Snack before exercise Yes/No
Snack after exercise Yes/No

Meals/ Snacks:
Breakfast_____
A.M. Snack _____
Lunch _____
P.M. Snack _____
Food in class, e.g. party _____

Supplies to be provided by parents: Blood Glucose Monitor and all monitoring supplies, Insulin and administration supplies, Glucagon emergency kit, snack foods, fast-acting glucose source, Ketone testing supplies, Insulin pump supplies if appropriate.

High blood glucose Management/Preventing Diabetic Ketoacidosis
If BG is above 250 mg/dl, wash hands and recheck. If still above 250:
→**If less than 2 hrs since last dose of Apidra, Humalog or Novolog,* recheck at 2 hrs after the last dose and continue as below.**
→**If 2 hrs or more since the last dose of Apidra, Humalog, or Novolog* give a correction dose using the correction factor formula.**
→ Check urine for ketones. If positive, drink 6-8 oz liquid with no calories every 30 minutes (e.g. water, diet soda)
→ **If moderate or large ketones at any time, call parent.**
→ Check BG and ketones every 2 hrs and give correction dose until BG reaches target range and ketones clear.
→ If BG and ketones are not decreasing after 4 hrs, call parent.
Additional Instructions for Insulin Pump Users:
→ If ketones are negative, check pump and site. If okay, give correction bolus by pump.
→ If ketones are positive, give correction bolus by syringe (not by pump) and have student change infusion set/site if able or call parent.
→ If initial correction bolus was given by pump, recheck BG in 1 hr. If BG has not decreased, give correction bolus by syringe and have student change infusion set/site if supplies are available or call parent.
→ Check BG and ketones every 2 hrs and give correction dose until BG reaches target range and ketones clear, by syringe until site is changed.
*If taking Regular, NPH or NPH mix insulin, call parent for direction.

Low blood glucose (hypoglycemia)
Some symptoms of low BG:
→Sweating →Hunger
→Headache →Dizziness
→Drowsiness →Confusion
→Trembling →Palpitations
→Blurred vision →Speech Impairment
Hypoglycemia protocol: the rule of 15
If blood glucose is less than 70 mg/dl or symptomatic (70 to 100 mg/dl)
→Eat/drink 15 grams of carbohydrate
→Check BG again in 15 minutes; if not above 70 mg/dl repeat treatment
→Check BG again in 15 minutes; if not above 70mg/dl repeat treatment and contact parent.
These items have 15 grams of carbohydrate:
→ 3 Glucose tablets → 4 oz of juice or soda (not diet)
→ 6-7 hard candies such as lifesavers
→1 tablespoon of table sugar or honey

Rx:
Glucagon: If child becomes unconscious, unable to cooperate, or has a seizure, give glucagon 0.5/1.0 mg subcutaneously. (Please circle dose)
Call 911 and parents. Do not force eating or drinking. Turn on side.

☐ I hereby certify that the above information is complete and I have provided the school with all information that they will need to reasonably care for and monitor my child's health related to his/her diabetes. I give permission for the school to talk to my doctor, nurse practitioner, and/or physician's assistant and/or nurse.

☐ Above I hereby certify that my child can monitor and manage his/her care without supervision from school staff except in emergencies.

Signature and dates: Parents_____ Student _____ Date _____

Physician_____ Date _____ School Representative and Title_____5/08

TURN OVER

Parental Authorization

By signing below, I agree:

1. That I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Lyons Township High School District 204 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District) , medication according to School Board Policy (5.14.1) and Medication Authorization Form.
2. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices.
3. I acknowledge the student is responsible for having the medication available as needed and the student has demonstrated competency in the proper way to use the medication.

For parent(s)/guardian(s) of students who use rescue inhalers and/or Epipens: I authorize the school district and its employees and agents to allow my child or ward to posses and use his/her asthma medication and/or epinephrine auto-injector as directed by physician: (1) while in school (2) while at a school-sponsored activity, (3) while under the supervision of school personnel (4) before or after normal school activities (5) while on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

4. To indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.
5. **It is incumbent of the parent(s)/guardians(s) to provide the school's health office with any changes or status updates.**

Parent/Guardian's Signature: _____

Parent/Guardian's Emergency Phone Number: _____