Endocrine Kids
44000 West 12 Mile Rd. Novi, MI 48377
Phone (248) 347-3344 Fax (248) 305-6845

Physician's Diabetes Treatment School Orders

Student Name ____ **Student ID** _______________

School: ______________________________________ **Grade:** _______ **Birth date:** _____________

☐ **STUDENT INDEPENDENT:** This student is capable of blood glucose monitoring, drawing and injecting insulin

☐ **STUDENT SUPERVISION/ASSISTANCE NEEDED (check all that apply)**
- ☐ Blood sugar testing
- ☐ Insulin administration **(see insulin orders)**

PARENT(S)/GUARDIAN AND STUDENT ARE RESPONSIBLE FOR PROVIDING AND MAINTAINING:
- Blood sugar meter, lancing device, lancets and strips
- Snacks
- Insulin and supplies
- Low blood sugar treatments
- Ketone strips
- Glucagon Emergency Kit

---

1. **MEALS / SNACKS:** Meals and snacks per parent according to student's meal plan.

2. **BLOOD SUGAR TESTING*:** Check finger stick blood sugars each day:
   - Daily before lunch
   - For signs/symptoms of high/low blood sugar
   - Other, as requested by MD/family _________________

3. **TREATMENT OF LOW BLOOD SUGARS:** For blood glucose **less than 80 mg/dL:**
   - Give 4 oz. juice, or 4 round **or** 3 square glucose tablets
   - Recheck blood sugar in 15 minutes. If less than 80 mg/dL, repeat treatment
   - If still less than 80 mg/dL after two treatments, call contact person
   - When greater than 80 mg/dL and more than one hour until next meal/snack, give snack of 15 grams of carbohydrate and a protein (e.g. 6 saltine crackers with cheese or peanut butter)

4. **SEVERE HYPOGLYCEMIA:** If unconscious, unable to swallow or having seizures:
   - Call 911
   - Assume low blood sugar is the problem and check blood sugar if possible
   - Do not put anything in student's mouth
   - Give Glucagon* IM, ☐ 1mg (>44 lbs) ☐ 0.5mg (<44 lbs)
   - Place student on side
   - Call contact person

5. **TREATMENT OF HIGH BLOOD SUGARS:** If student has symptoms of high blood sugar (increased thirst, flushed, extra trips to the bathroom) or blood sugar is **>300 mg/dL:**
   - Provide access to no-calorie fluids and toilet facilities
   - If ketone strips available, test urine ketones
   - If ketones are present or student is lethargic, vomiting or has abdominal pain, call contact person
   - If unable to reach contact person, call school nurse. If school nurse not available, **call 911**

Endocrine Kids
44000 West 12 Mile Rd. Novi, MI 48377
Phone (248) 347-3344 Fax (248) 305-6845

PHYSICIAN INSULIN TREATMENT ORDERS

Student Name ____

Check those insulin orders that apply for student:

☐ **Daily fixed insulin dose** **Insulin type:** _______________	☐ **Carbohydrate : Insulin ratio (to be given before eating unless otherwise noted)** **Insulin type: Novolog/Humalog** *(circle)*	☐ **Blood Sugar Correction** **Insulin type: Novolog/Humalog** *(circle)*
Breakfast _____ units AM Snack _____ units Lunch: ______ units PM Snack: ______ units	Breakfast ____ units per ____ grams carb Lunch ____ units per ____ grams carb Snacks: ____ units per ____ grams carb	Blood Sugar Correction is only given if it has been greater than 3 hours since last insulin dose. **See chart below**

Blood Sugar Correction Dose

☐ 1:30 over 150		☐ 1:40 over 150		☐ 1:50 over 150		☐ 0.5/50 over 150		☐ Other
151-180	1 unit	151-190	1 unit	151-200	1 unit	151-200	0.5unit	units
181-210	2 units	191-230	2 units	201-250	2 units	201-250	1 unit	units
211-240	3 units	231-270	3 units	251-300	3 units	251-300	1.5 units	units
241-270	4 units	271-310	4 units	301-350	4 units	301-350	2 units	units
271-300	5 units	311-350	5 units	351-400	5 units	351-400	2.5 units	
301-330	6 units	351-390	6 units	>400	6 units	>400	3 units	
331-360	7 units	>390	7 units					
361-390	8 units							
>390	9 units							
**Call contact person if over 400								

☐ Parent may adjust insulin doses as needed.

Physician signature: ________________________________ **Date:** ____________________

I have read the school orders and reviewed my child's treatment plan with my health care provider. I will provide updated orders from my child's healthcare provider as changes to my child's treatment plan occur. I authorize the exchange of educational / protected health information between my child's healthcare team and school personnel.

Parent/Guardian signature: ____________________________ **Date:** ____________________

***Registered nurse may train/delegate school personnel to perform these procedures at school when the RN determines it is safe to do so.**