

# HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN

## STUDENT WITH DIABETES ON INSULIN INJECTIONS

(MONTANA FORM VERSION 5/22/18)

<b>EFFECTIVE DATE:</b>	End Date:
<b>STUDENT'S NAME:</b>	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.

<input type="checkbox"/> Before lunch	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Before PE	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Before leaving school	<input type="checkbox"/> Other: _____

Where to check:  Anywhere  Classroom  Health office  Other: \_\_\_\_\_

**Insulin:**  Humalog/NovoLog/Apidra  Other: \_\_\_\_\_  
 Insulin Delivery:  Syringe/vial  Pen

**Carbohydrate Coverage:**

Breakfast: Give 1 unit for \_\_\_\_\_ grams of carbohydrate **OR**  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 insulin for every \_\_\_\_\_ mg/dl of blood glucose above target blood glucose of \_\_\_\_\_ mg/dl.  
 BG Range: \_\_\_\_\_ Give \_\_\_\_\_ units  
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**Formula used to calculate correction:**  
 Blood glucose \_\_\_\_\_ minus (-) target blood glucose \_\_\_\_\_ = \_\_\_\_\_.  
 Then divide (÷) by correction factor (\_\_\_\_\_) = \_\_\_\_\_.

Give Correction Scale Before Lunch Only  Other: \_\_\_\_\_

**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 **OR**  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 monitoring:  Yes  No

**Diabetes Medications:**

**Glucagon (for emergency low blood glucose)** - Dose:  0.5 mg  1.0 mg Given IM or SC per thigh or arm  
 Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Times to be given: \_\_\_\_\_  
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<b>HCP Assessment of Student's Diabetes Management Skills:</b>	<b>Notes:</b>																			
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Skill</th> <th style="width: 25%;">Independent</th> <th style="width: 25%;">Needs supervision</th> <th style="width: 25%;">Cannot do</th> </tr> </thead> <tbody> <tr> <td>Check blood glucose</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Count carbohydrates</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Calculate insulin dose</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Injection</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p><input type="checkbox"/> Student may advance in independence through school year if school/parent agrees.</p>		Skill	Independent	Needs supervision	Cannot do	Check blood glucose				Count carbohydrates				Calculate insulin dose				Injection		
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<b>HEALTHCARE PROVIDER</b>	Date:
<b>SIGNATURE/STAMP:</b>	
Parent/Guardian	
<b>Signature:</b>	Date:

**UPDATES TO THE  
HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN  
STUDENT WITH DIABETES ON INSULIN INJECTIONS**

<b>STUDENT'S NAME:</b>	Date of Birth:
<b>DIABETES HEALTHCARE PROVIDER INFORMATION</b> Name:	
Phone #:	Fax #:
Email:	
<b>SCHOOL:</b>	School Fax:

**Effective  
Date:**

**Update:**

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

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