

CUMBERLAND COUNTY SCHOOLS
DIABETES CARE PLAN
Physician's Orders for Student with Diabetes

Rev. 06/2022

Student _____ DOB _____ School _____ Grade _____
 Parent/Guardian _____ Phone _____ Phone _____
 Home Address _____ City _____ State _____ Zip _____
 Emergency Contact _____ Phone _____ Phone _____
 Physician _____ Office _____ FAX _____

Child has Type I or Type II Child's Blood Sugar Target Range: > _____ mg/dl to < _____

When to Monitor Blood Sugar:

<input type="checkbox"/> before breakfast	<input type="checkbox"/> before lunch	<input type="checkbox"/> before snack	<input type="checkbox"/> before PE/exercise
<input type="checkbox"/> after breakfast	<input type="checkbox"/> after lunch	<input type="checkbox"/> after snack	<input type="checkbox"/> after PE/exercise
<input type="checkbox"/> before going home	<input type="checkbox"/> as needed for signs/symptoms of low or high blood sugar		

If child has a CGM and is symptomatic, confirm with finger stick.

What diabetes medications to be given at school:

<input type="checkbox"/> Apidra	<input type="checkbox"/> Humalog	<input type="checkbox"/> Novolog	<input type="checkbox"/> Metformin
<input type="checkbox"/> Glucose tabs	<input type="checkbox"/> Glucagon	<input type="checkbox"/> Other: _____	

Method of insulin delivery during school hours:

<input type="checkbox"/> Insulin Pump: <input type="checkbox"/> Animas <input type="checkbox"/> Medtronic <input type="checkbox"/> OmniPod <input type="checkbox"/> t:slim		Basal Settings	
Insulin to carbohydrate ratio:	Insulin sensitivity factor:	Time	Units/Hours
Breakfast 1 unit per _____ grams/carbs	Breakfast 1 unit per _____ points > _____		
Lunch 1 unit per _____ grams/carbs	Lunch 1 unit per _____ points > _____		
Snack 1 unit per _____ grams/carbs	Snack 1 unit per _____ points > _____		

Vial/Syringe Insulin Pen

Carbohydrate Counting (use rapid acting insulin)	Insulin Sensitivity Factor	Sliding Scale (use rapid acting insulin)													
1 unit per _____ <input type="checkbox"/> meals/snacks grams/carbs <input type="checkbox"/> Fix dose { <table style="display: inline-table; vertical-align: middle; margin-left: 10px;"> <tr><td>Breakfast</td><td>_____</td><td>units</td></tr> <tr><td>Lunch</td><td>_____</td><td>units</td></tr> <tr><td>Dinner</td><td>_____</td><td>units</td></tr> <tr><td>Snacks</td><td>_____</td><td>units</td></tr> </table>	Breakfast	_____	units	Lunch	_____	units	Dinner	_____	units	Snacks	_____	units	Target blood sugar: _____	Target Range:	
	Breakfast	_____	units												
Lunch	_____	units													
Dinner	_____	units													
Snacks	_____	units													
Insulin must be given anytime the child eats carbs, except in the case when treating a low blood sugar. Inject insulin { <input type="checkbox"/> before eating <input type="checkbox"/> after eating	Insulin sensitivity factor: _____	100-149	Give _____ units												
	1 unit per _____ points > _____	150-199	Give _____ units												
	Current BS - Target BS	200-249	Give _____ units												
	Insulin sensitivity factor =	250-299	Give _____ units												
	Sensitivity factor may not be given more frequently than every 2 hours due to the risk of low blood sugar.	300-349	Give _____ units												
	Number of Units	350-399	Give _____ units												
		400-449	Give _____ units												
		450-499	Give _____ units												
	> 500	Give _____ units													
	Other	Give _____ units													

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Blood sugar (BS) at which parent/guardian should be notified: LOW < _____ mg/dl or HIGH > _____ mg/dl.	
HYPOGLYCEMIA	HYPERGLYCEMIA
Do not send student <u>unaccompanied</u> to the office if symptomatic or blood sugar (BS) < 70mg/dl.	If blood sugar (BS) >300mg/dl with ketones or 2 consecutive unexplained BS >250 mg/dl (with or without ketones), i.e. malfunctioning pump the student may require insulin via injection and/or new infusion site/set.
➤ Test blood sugar and treat symptoms. If blood glucose meter is not available treat symptoms per care plan guidelines.	➤ First contact parent/guardian, if not available call school nurse who will call health care provider for further instructions.
➤ Blood sugar < 70mg/dl and/or symptomatic: treat with 10 to 15 grams carbohydrate snack (juice, sugar tabs, etc.) and recheck BS in 15 minutes.	➤ An order for insulin specific to the incident may be faxed from the health care provider.
➤ Mild symptoms: treat with snack, juice, sugar tabs, etc., recheck and repeat every 15 minutes until BS > 70mg/dl, then give snack with protein or lunch.	➤ Check urine ketones if BS > _____ mg/dl. and recheck in 1 hour.
➤ Moderate symptoms: if able to swallow, administer glucose gel, frosting, etc. Repeat until BS is above 70mg/dl, then give snack with protein or lunch.	➤ If trace/moderate ketones are present call parent/guardian, provide water and student should remain under medication clerk observation until ketones clear.
➤ Call 911: if severe symptoms (which may include seizures, unconscious) or unable/unwilling to take gel or juice: administer Glucagon _____ mg(s) by intramuscular or intranasally injection and contact parent/guardian.	➤ Student will be sent home from school when ketones are large or shows symptoms of nausea, vomiting, tired, thirsty, dry mouth, difficulty breathing, fruity breath, or confused. Call 911 if severe symptoms persist.

Student's Self Care: The ability level is determined by health care provider with input from school nurse & parent/guardian.

Totally independent management	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Self-injects with trained staff supervision	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Tests independently	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Injections to be done by trained staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Needs verification of BS by staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Self-treats mild hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Assist/testing to be done by trained staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Monitors own snacks and meals	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Administers insulin independently	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Independently counts carbohydrates	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Self-injects with verification of dose	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Tests and interprets urine/blood ketones	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Children with Disabilities: It is and shall remain the policy of Cumberland County Board of Education not to discriminate on the basis of gender or disability in its educational programs, activities, or employment policies as required by Title IX of the 1972 Educational Amendments, the 1990 Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973. It is the policy of the Cumberland County Board of Education to provide equal employment opportunities on a nondiscriminatory basis, regardless of sex, race, age, national origin, disability or religion. Cumberland County Board of Education Policy 1730/4022/7231. The individual designated to ensure district compliance with Section 504 is the Executive Director of Student Services, phone (910) 678-2433, and the mailing address is Cumberland County Schools, PO Box 2357, Fayetteville NC 28302.

Does your child have a Section 504 Plan? Yes No Does your child have an Individual Education Plan (IEP)? Yes No

Release of Liability: Realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, the Cumberland County Schools, and the Cumberland County Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year. **Parent/Guardian Signature:** _____ **Date:** _____

MD Stamp Below	Physician Signature: _____	Date: _____
	Principal Signature: _____	Date: _____
	School Nurse Signature: _____	Date: _____

Copy: Director of Health Services Public Health School Nurse If applicable cc:
504 Coordinator Cum. Folder Special Needs Nurse
EC Case Manager School Bus Driver