

# **HEALTH CARE PROVIDER (HCP) ORDERS FOR STUDENTS WITH DIABETES IN SCHOOL STUDENTS WITH INSULIN PUMPS**

## **OVERVIEW**

This form is intended to help standardize information for student with diabetes. It has been designed to cover as many situations that may apply to the student while at school. In most cases, the majority of the blank space will not need to be filled or the answer may be similar to the previous space. Generally, the plan should be worked out between the parent and the school nurse and then submitted to the HCP to authorize.

**The following is a brief description of each section:**

## **HYPOGLYCEMIA (LOW BLOOD SUGAR)**

The blank lines are for treatment plans for various situations. The information in parenthesis is some guidelines that can either be used or crossed out if another treatment is desired.

## **PUMP INSTRUCTIONS**

This section is intended to provide school personnel with the basic information needed for safe management during the school day. This includes information about the pump and information regarding bolus administration.

## **DISASTER INSULIN DOSAGE**

This includes doses of insulin that are normally not given at school, but that during a disaster situation may be needed. Since the food supply may be limited, it is recommended that the usual dosage be reduced to 80%. A copy of this order form should be included in the Disaster Kit. Disaster dosages must be reviewed and updated anytime the student's insulin requirements change.

## **STUDENT=S SELF CARE**

This is intended to have agreement as to the extent to which the student can manage her or his own care and to clarify to what degree the school is responsible for care. If the student is totally independent the first statement only needs to be initialed. The blank at the bottom of this section allows for other situations which might arise regarding the student=s diabetes management.

## **SIGNATURES AND START/TERMINATION DATES**

Each person involved in verifying the student=s ability to participate in self-care should sign and date the form. Start and review termination dates must be noted.

**HEALTH CARE PROVIDER (HCP) ORDERS FOR STUDENTS WITH DIABETES IN SCHOOL  
FOR STUDENTS WITH INSULIN PUMPS**

STUDENT'S NAME \_\_\_\_\_ Student=s Birthdate \_\_\_ / \_\_\_ / \_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Emergency numbers for parents (phone) \_\_\_\_\_ (cellular) \_\_\_\_\_ (pager) \_\_\_\_\_

Doctor=s Phone Number \_\_\_\_\_ Other contacts \_\_\_\_\_

**HYPOGLYCEMIA** - (fill-in individualized instructions on line or use those in parenthesis)

**Unconscious** \_\_\_\_\_ (**Phone 911**) (Other orders) \_\_\_\_\_

Blood sugar < 60 and symptomatic \_\_\_\_\_ (Juice, pop, candy) \_\_\_\_\_

Blood sugar < 100 and symptomatic \_\_\_\_\_ (Crackers/cheese) \_\_\_\_\_

Blood sugar < 80 and asymptomatic \_\_\_\_\_ (Feed partial meal) \_\_\_\_\_

Blood sugar > 100 and symptomatic \_\_\_\_\_ (Feed partial meal) \_\_\_\_\_

**Blood sugar at which parent should be notified - low** \_\_\_\_\_ **high** \_\_\_\_\_

**Target range for blood glucose is:**  70-150  70-180  Other \_\_\_\_\_

**Type of pump:** \_\_\_\_\_ **Basal rates:** \_\_\_\_\_ 12:00 am to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_

**Type of insulin in pump:** \_\_\_\_\_ **Type of infusion set:** \_\_\_\_\_

**Insulin/carbohydrate ratio:** \_\_\_\_\_ **Correction factor:** \_\_\_\_\_

**Blood sugar check with Insulin Bolus:**  Before lunch  Before snack  Other: \_\_\_\_\_

**Check urine ketones:**  ≥ 250 blood sugar  ≥ \_\_\_\_\_ blood sugar  never

**If urine ketones** (trace, small, moderate, large) call parents (circle one or more)

**DISASTER INSULIN DOSAGE** - in case of disaster how much insulin should be given? Recommend **80%** of usual dose.

Basal rates: \_\_\_\_\_ 12:00 am to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_

Insulin/carbohydrate ration: \_\_\_\_\_ Correction factor: \_\_\_\_\_

Student=s Self Care - (ability level)	Initials of:	Parent	Doctor	School Nurse
<b>Totally independent management</b> <b>or</b>		_____	_____	_____
1. Student tests independently <b>or</b>		_____	_____	_____
Student needs verification of number by staff <b>or</b>		_____	_____	_____
Assist/Testing to be done by school nurse		_____	_____	_____
2. Student counts carbohydrates independently <b>or</b>		_____	_____	_____
Student consults with parent for carb count		_____	_____	_____
3. Student calculates corrective bolus independently <b>or</b>		_____	_____	_____
Student needs assistance calculating corrective bolus		_____	_____	_____
4. Student gives bolus independently <b>or</b>		_____	_____	_____
Student gives bolus with verification of number <b>or</b>		_____	_____	_____
Bolus to be done by school nurse		_____	_____	_____
5. Student self treats mild hypoglycemia		_____	_____	_____
6. Student monitors own snacks and meals		_____	_____	_____
7. Student tests and interprets own urine ketones		_____	_____	_____

HCP \_\_\_\_\_ (print/type) \_\_\_\_\_ (Signature) \_\_\_ / \_\_\_ / \_\_\_ (Date)

Parent \_\_\_\_\_ (print/type) \_\_\_\_\_ (Signature) \_\_\_ / \_\_\_ / \_\_\_ (Date)

School Nurse \_\_\_\_\_ (print/type) \_\_\_\_\_ (Signature) \_\_\_ / \_\_\_ / \_\_\_ (Date)

**Start date:** \_\_\_ day \_\_\_ mo. \_\_\_ yr. **Termination date:** \_\_\_ day \_\_\_ mo. \_\_\_ yr. **Or** \_\_\_ end of school year

**Must be renewed at beginning of each school year.**