Washoe County School District
STUDENT HEALTH SERVICES
(Fax 775-353-5968)

LICENSED HEALTH CARE PROVIDER DIABETES ORDERS

THIS ORDER EXPIRES AT THE END OF THE SCHOOL YEAR

Date: _____

STUDENT NAME: _____ **DOB:** **SCHOOL:**

PART I

Diabetes Mellitus ☐ **Type I** ☐ **Type II**

☐ This student is **NOT** independent in self-managing all aspects of his/her diabetes care. I authorize the school nurse, in collaboration with the parent/guardian, to determine the level of supervision and/or assistance required by the student for each of the following diabetes orders.

PART II

Specific Insulin Information:

ROUTINE (Meal time) Insulin ☐ No ☐ Yes If yes, complete the following information:
Insulin Type ________________________________

Oral Medication ☐ No ☐ Yes If yes, attach "Consent and Request for Medication during School Hours," HEA-F205

HOME insulin information: ____

Insulin Injection via Syringe or Insulin Pen: ☐ No ☐ Yes If Yes, complete the following information:

Base Unit(s) ☐ No ☐ Yes If yes, please indicate number of routine base units to be given: _________

1) ROUTINE Blood Glucose Correction: ___ unit insulin for every ____ points blood glucose >____ mg/dl

2) ROUTINE Insulin-to Carbohydrate Coverage:

Breakfast Insulin-to-Carbohydrate Coverage ____ unit insulin for every _____ grams carbohydrates

Lunch Insulin-to-Carbohydrate Coverage ___ unit insulin for every _____ grams carbohydrates

Dinner Insulin-to-Carbohydrate Coverage ______ unit insulin for every _____ grams carbohydrates

☐ Subtract ________________ unit(s) if ____

3) NON-ROUTINE Insulin-to-Carbohydrate Coverage: ___ unit insulin for every ______ grams carbohydrates

Individual Orders:

____

____

PART III **Student Name:** _____ **DOB:**

Infusion via Insulin Pump:

Pump Type: ___________________________

*Pump setting are established by the student's LHCP and should not be changed by the school staff.

*If pump malfunctions, parent is to be called to come and provide diabetes care to student. School staff are not to manipulate insulin pump if it malfunctions.

*Correction bolus and/or carbohydrate coverage are to be provided per pump calculator.

*All blood glucose levels should be entered into the pump for administration of pump-calculated correction unless otherwise indicated on the pump - ___ NO ____YES

☐ Refer to Insulin Injection via Syringe or Insulin Pen Orders on Page 1 (Part II) if pump is unavailable.

*Individual orders: ____

Part IV

Nutrition and Monitoring:

Snacks:

☐ Daily snacks ☐ AM (before lunch) _______________ ☐ PM (after lunch) ________________________

Individual Orders: ____

Blood Glucose Testing:

***See "Nursing Services for Students with Diabetes Procedure" (HEA-P102) to follow standard of care for diabetes glucose testing.**

_____ Before PE _____After PE

☐ Daily at Dismissal ______After School Program/Extracurricular Activity _____ Before Snack

☐ Additional Glucose Testing as Follows: ____

Ketone Testing:

***See "Nursing Services for Students with Diabetes Procedure" (HEA-P102) to follow standard of care for diabetes management for ketone testing**

☐ Urine ☐ Blood

Individual Orders: ____

____

PART V **Student Name: _____** **DOB:**

LOW BLOOD GLUCOSE ORDERS:

- If blood glucose is < 75 OR _____ (alternative value must be >75mg/dl) or **student has symptoms:**

***See "Nursing Services for Students with Diabetes Procedure" (HEA-P102) to follow standard of care for diabetes management for hypoglycemia**

☐ After blood glucose increases to ≥ 75, student will consume fat **and** protein snack or meal, and then resume regular school activities.

Individual Orders: ____

HIGH BLOOD GLUCOSE ORDERS:

If blood glucose is >300 mg/dl OR ____ alternative (must be <300 mg/dl)

If glucometer reads **HI** on two consecutive BG checks, administer _____ units of insulin, provided it has been 3 to 4 hours since student's last insulin dose.

***See "Nursing Services for Students with Diabetes Procedure" (HEA-P102) to follow standard of care for diabetes management for hyperglycemia**

PART VI

EMERGENCY INTERVENTIONS: 911 will be activated per "Nursing Services for Students with Diabetes Procedure" (HEA-P102)

Part VII

Continuous Blood Glucose Monitor: ☐ No ☐ Yes If Yes, complete the following information:

Monitor Type: _________________

Interventions for alarms when continuous monitor alarms ____

Monitor to be used as blood glucose monitor in order to dose insulin ☐ No ☐ yes

Name of FDA approved monitor: ___________________________________

Individual orders: ____

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PART VIII **Student Name: _____** **DOB:**

Field Trip and afterschool activities:

Student may attend field trip/afterschool activity ☐ No ☐ Yes If yes, complete the following information:

☐ Continue above orders without additions.

☐ Continue above orders with the following addition(s): ____________________

Overnight Field trip additions

☐ Additional Diabetic Management orders during the night ____________________

Consent and Request for Diabetes Care and Medication Assistance during School Hours:

The undersigned parent or guardian hereby requests the Washoe County School District to assist and supervise the above named student in some or all aspects of his or her diabetes care the administration of the above described medication, as set forth, and consents to such assistance and supervision while the student is present on a WCSD campus, during WCSD transportation, and while participating in school-sponsored activities.

In addition, the undersigned parent or guardian hereby gives permission to the school nurse at the above described school to exchange confidential information, if needed, regarding the student's diabetes care and/or medication, with the undersigned health care provider or physician; and further hereby agrees to assume all risk and responsibility regarding the student's diabetes care or medication and to defend and hold the Washoe County School District, the Board of Trustees of the District, and all agents of the District harmless from any and all losses or liability, claims, and expenses, including any and all claims for contribution or indemnity by any party for their participation in assisting and supervising the above named student in diabetes care, including administration of medication.

The undersigned parent hereby agrees to provide the above named student with all diabetes medication, supplies, and equipment required to provide the student with the above diabetes care, including medication administration, while the student is present on a WCSD campus, during WCSD transportation, and while participating in school-sponsored activities and the undersigned parent or guardian agrees to assume all responsibility for maintaining the supply of the medication, supplies, and equipment and replacing such medication when its effectiveness has lapsed by reason of time. Medications that are kept in the school health office may not be sent home with students. Medications not claimed or picked up by the parent/guardian or their designee by the day following the last day of the school year will be disposed of by the school nurse or her designee.

WCSD Carbohydrate/ School Menu Information:

Carbohydrate calculations are based on the most current menus provided by Washoe County School District Nutrition Services Department. Food substitutions and other variables could alter the student's carbohydrate ratio and the insulin dosage administered.

Note: Medications that are kept in the school health office may not be sent home with students. Medications not claimed or picked up by the parent/guardian or their designee by the day following the last day of the school year will be disposed of by the school nurse or her designee.

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STUDENT NAME: _____ **DOB:**

I am in agreement with the orders set forth as stated above:

Parent/Guardian Name (please print)__________________________________ Phone: ___________________

Parent/Guardian Signature: ______________________________________ Date: ____________________

Health Care Provider Name (please print) ____

PHONE _________________________________ FAX ____

Health Care Provider Signature: _______________________________________Date: ___________

School Nurse Name/Title (please print) ____

School Nurse Signature: ____ Date: ___________