**Carbohydrate counting**
Notify the nurse of any changes in my child’s care or condition

**Insulin Delivery**
- **Parent/Independent**
- **Pen/Fixed Dose Insulin:**
- **Syringe/Parent**
- **Pump (make/model):**

**Carbohydrate (CHO) Coverage per meal:**
- **unit(s) of insulin Sub-Q per grams of CHO at breakfast**
- **unit(s) of insulin Sub-Q per grams of CHO at lunch**
- **unit(s) of insulin Sub-Q per grams of CHO at dinner**

**Carbohydrate Dose Adjustment Prior To Strenuous Exercise Within Minutes:**
- **Use exercise/PE CHO ratio of unit(s) of insulin per grams of CHO at breakfast**
- **Use exercise/PE CHO ratio of unit(s) of insulin per grams of CHO at lunch**
- **Use exercise/PE CHO ratio of unit(s) of insulin per grams of CHO at dinner**

**Correction Dose:**
- **Give unit(s) of insulin Sub-Q for every mg/dl greater than BG of mg/dl**
- **If pre-breakfast BG less than mg/dl, subtract unit(s) of insulin dose**
- **If pre-lunch BG less than mg/dl, subtract unit(s) of insulin dose**
- **If pre-dinner BG less than mg/dl, subtract unit(s) of insulin dose**

**Fixed Dose Insulin:**
- **unit(s) of insulin Sub-Q given before school meals**

**Snack Insulin Coverage:**
- **No snack coverage**
- **Snack coverage if BG > mg/dl**
- **unit(s) of insulin Sub-Q per grams of CHO**

**Insulin Dose Administration Principles**
*See page 2 for Hyperglycemia management*

**Insulin should be given:**
- **Before meals**
- **Before snacks**
- **Other times (please specify):**
- **For correction if BG > mg/dl and hours since last dose/bolus**
- **If CHO intake cannot be predetermined, insulin should be given no more than minutes after start of meal/snack**
- **If parent/guardian requests, insulin should be given no more than minutes after start of meal/snack**
- **Use pump or bolus device calculations per programmed settings, once settings have been verified**
- **Parent/Guardian has permission to increase/decrease insulin correction dose by +/- one (1) unit to three (3) units**

**Independent Insulin Administration Skills & Supervision Needs**
*Skills to be verified by school nurse*

**Other Diabetes Medication**
- **Name of Medication**
- **Time**
- **Dosage**
- **Route**
- **Possible Side Effects**

**Healthcare Provider Authorization**
By signing below, I authorize:
- The designated school personnel to administer the medication and treatment orders as prescribed above.
- Provide the necessary diabetes management supplies and equipment; and
- Notify the nurse of any changes in my child’s care or condition.

**Provider Name (PRINT):**

**Provider Signature:**

**Parent/Guardian Signature:**

**Acknowledged and received by:**

**School Nurse:**
Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form
Valid from: Start ___/___/___ to End ___/___/___ or for School Year _________

Student Name: __________________________ DOB: __________________________

Blood Glucose (BG) Monitoring:

☐ Before meals  ☐ Before PE/Activity  ☐ After PE/Activity  ☐ Prior to dismissal
☐ For symptoms of hypo/hyperglycemia & anytime the student does not feel well
☐ Additional monitoring per parent/guardian request
☐ Student may independently check BG*

Continuous Glucose Monitoring

☐ Uses CGM  Make/Model: __________________________

Alarms set for:  Low _____ mg/dl  High _____ mg/dl  ☐ If sensor falls out at school, notify parent/guardian

Blood Glucose Monitoring*  *Self-management skills to be verified by school nurse

Hypoglycemia Management*

Mild or Moderate Hypoglycemia (BG below _____ mg/dl)

☐ Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious & able to swallow.
☐ Suspend pump for BG < _____ mg/dl and restart pump when BG > ______ mg/dl
☐ Student should consume a meal or snack within _____ minutes after treating hypoglycemia
☐ Other: ____________________________________

Always treat hypoglycemia before the administration of meal/snack insulin

Repeat BG check 15 minutes after use of quick-acting glucose

• If BG still low, re-treat with 15 grams quick-acting CHO as stated above
• If BG in acceptable range and it is lunch or snack time, have student eat and cover meal CHO per orders
• If CGM in use and BG >70 mg/dl and arrow going up, no need to recheck

Student may self-manage mild or moderate hypoglycemia and notify the school nurse*:  ☐ Yes  ☐ No

Severe Hypoglycemia (includes any of the following symptoms):

• Unconsciousness  • Semi-consciousness  • Inability to control airway
• Inability to swallow  • Seizure  • Worsening of symptoms despite treatment/retreatment as above

☐ GLUCAGON injection:  ☐ 1 mg  ☐ 0.5 mg IM or Sub-Q

• Place student in the recovery position
• Suspend pump, if applicable, and restart pump at BG > _____ mg/dl
• Call 911 and state glucagon was given for hypoglycemia; notify parent/guardian

☐ If glucagon is not available or there is no response to glucagon, administer glucose gel inside cheek, even if unconscious or seizing. If glucose gel is administered, place student in recovery position.

Hyperglycemia Management*  *Self-management skills to be verified by school nurse

If BG greater than _____ mg/dl, or when child complains of nausea, vomiting, and/or abdominal pain, check urine/blood for ketones.

If urine ketones are trace to small or blood ketones _____ mmol/L:

• Give _____ ounces of sugar-free fluid or water per hour as tolerated
• Give insulin as listed in insulin orders no more than every _____ hour(s)

If urine ketones are moderate to large or blood ketones greater than _____ mmol/L:

• Give _____ ounces of sugar-free fluid or water per hour as tolerated
• If student uses pump, disconnect pump
• Give insulin as listed in insulin orders no more than every _____ hour(s) by injection

If large ketones and vomiting or large ketones and other signs of ketoacidosis, call 911. Notify parent/guardian.

Recheck BG and ketones ______ hours after administering insulin

Contact parent/guardian for:  ☐ BG > _______ mg/dl  ☐ Ketones ______ mmol/L

Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse*:  ☐ Yes  ☐ No

Ketone Coverage

For ketones trace to small (urine)/<____ mmol/L (blood)  For ketones moderate to large (urine)/>____ mmol/L (blood)

☐ Correction dose plus _____ unit(s) of insulin
☐ _____ unit(s) of insulin

Parent/Guardian Name: __________________________  Signature: __________________________  Date: __________________________

Provider Name: __________________________  Signature: __________________________  Date: __________________________

Acknowledged and received by: __________________________  School Nurse: __________________________  Date: __________________________
### Physical Education, Physical Activity, and Sports

- **Self-management skills to be verified by school nurse**
- □ Avoid physical education/physical activity/sports if:
  - □ BG < _______ mg/dl  □ BG > _______ mg/dl
  - □ Trace/small ketones present  □ Moderate/large ketones present
- □ If BG is ≤ _______ mg/dl, give 15 grams of CHO and return to physical education/physical activity/sports
- □ May disconnect pump for physical education/physical activity/sports
- □ Student may set temporary basal rate for physical education/physical activity/sports*
- □ Other:
- □ Check BG prior to dismissal
  - □ If BG is not > _______ mg/dl, give _______ grams carbohydrate snack
  - □ BG must be > _______ mg/dl for bus ride/walk home
- □ Only check BG if symptomatic prior to bus ride/walk home
- □ Allow student to carry quick-acting glucose for consumption on bus, as needed for hypoglycemia*
- □ Student must be transported home with parent/guardian if (specify):
- □ Other:

### Transportation

- **Self-management skills to be verified by school nurse**
- □ Continue to follow orders contained in this medical management plan
- □ Other:

### Pump Management

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<th>Type of Pump:</th>
<th>Pump start date:</th>
<th>Child Lock:</th>
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<th>□ Off</th>
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</table>

**Additional Hyperglycemia Management:**
- □ If BG > _______ mg/dl and has not decreased over _____ hours after bolus, consider infusion site change. Notify parent/guardian
- □ For infusion site failure:
  - □ Give insulin via syringe or pen
  - □ Change infusion site
- □ For suspected pump failure, suspend or remove pump and give insulin via syringe or pen
- □ If BG > _______ mg/dl and moderate to large ketones, student should change infusion site and give correction dose by pen or syringe

**Comments:**

### Independent Pump Management Skills and Supervision Needs*

- **Skills to be verified by school nurse. Supervision will be provided if not fully independent when appropriate**

**Student is independent in the pump skills indicated below:**
- □ Carbohydrate counting
- □ Reconnect pump at infusion set
- □ Give self-injection if needed

**Additional Orders:**
- □ Please FAX copies of BG/insulin diabetes management records every _____ weeks (FAX number: ____________)

**Other orders:**

### Parent/Guardian Consent for Self-Management

- I acknowledge that my child ☐ is  ☐ is not authorized to self-manage as indicated by my child’s health care provider.
- I understand the school nurse will work with my child to learn self-management skills he/she is not currently capable of or authorized to perform independently.

**My child has permission to independently perform the diabetes tasks listed below as indicated by my child’s health care provider:**
- □ Blood glucose monitoring  □ Insulin administration  □ Pump management
- □ Carbohydrate counting  □ Insulin dose calculation  □ Other:

**Parent/Guardian Name:** ____________  **Signature:** ____________  **Date:** ____________

**Provider Name:** ____________  **Signature:** ____________  **Date:** ____________

**Acknowledged and received by:**  **School Nurse:** ____________  **Date:** ____________