



Demographics				
<b>Student Name:</b>		<b>D.O.B.:</b>	<b>Grade:</b>	<b>Diagnosis:</b>
<b>Parent/Guardian:</b>		<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>
Insulin Orders				
<b>Insulin Dosing:</b>				
<input type="checkbox"/> Carbohydrate (CHO) coverage	<input type="checkbox"/> Correction dose only	<input type="checkbox"/> Correction dose plus CHO coverage		<input type="checkbox"/> Fixed dose
<input type="checkbox"/> Fixed dose with correction scale	<input type="checkbox"/> See attached dosing scale			
<b>Insulin(s):</b>				
<input type="checkbox"/> <b>Rapid Acting:</b>	<input type="checkbox"/> Apidra	<input type="checkbox"/> Humalog	<input type="checkbox"/> Novolog	<input type="checkbox"/> Admelog
<input type="checkbox"/> Other (specify): _____				
<input type="checkbox"/> Any of the <b>Rapid Acting</b> insulins may be substituted for the others				
<input type="checkbox"/> <b>Long Acting</b> (if given at school): _____ Give _____ unit(s) of insulin Sub-Q at _____ (time)				
<b>Insulin Delivery:</b>				
<input type="checkbox"/> Pen	<input type="checkbox"/> Syringe	<input type="checkbox"/> Pump (make/model): _____		
<b>Carbohydrate (CHO) Coverage per Meal:</b>				
<input type="checkbox"/> _____ unit(s) of insulin Sub-Q per _____ grams of CHO at breakfast				
<input type="checkbox"/> _____ unit(s) of insulin Sub-Q per _____ grams of CHO at lunch	<input type="checkbox"/> _____ unit(s) of insulin Sub-Q per _____ grams of CHO at dinner			
<b>Carbohydrate Dose Adjustment Prior To Strenuous Exercise Within _____ Minutes:</b>				
<input type="checkbox"/> Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at breakfast				
<input type="checkbox"/> Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at lunch				
<input type="checkbox"/> Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at dinner				
<b>Correction Dose:</b>				
<input type="checkbox"/> Give _____ unit(s) of insulin Sub-Q for every _____ mg/dl greater than BG of _____ mg/dl				
<input type="checkbox"/> If pre-breakfast BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose				
<input type="checkbox"/> If pre-lunch BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose				
<input type="checkbox"/> If pre-dinner BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose				
<input type="checkbox"/> <b>Fixed Dose Insulin:</b> _____ unit(s) of insulin Sub-Q given before school meals				
<input type="checkbox"/> <b>Split Insulin Dose:</b>				
Give _____ unit(s) or _____ % of meal insulin dose Sub-Q before meal and _____ unit(s) or _____ % of meal insulin dose Sub-Q after meal				
<b>Snack Insulin Coverage:</b>				
<input type="checkbox"/> No snack coverage	<input type="checkbox"/> Snack coverage if BG > _____ mg/dl			
<input type="checkbox"/> _____ unit(s) of insulin Sub-Q per _____ grams of CHO				
Insulin Dose Administration Principles* <span style="float: right;">*See page 2 for Hyperglycemia management</span>				
Insulin should be given:				
<input type="checkbox"/> Before meals	<input type="checkbox"/> Before snacks	<input type="checkbox"/> Other times (please specify): _____		
<input type="checkbox"/> For correction if BG > _____ mg/dl and _____ hours since last dose/bolus				
<input type="checkbox"/> If CHO intake cannot be predetermined, insulin should be given no more than _____ minutes after start of meal/snack				
<input type="checkbox"/> If parent/guardian requests, insulin should be given no more than _____ minutes after start of meal/snack				
<input type="checkbox"/> Use pump or bolus device calculations per programmed settings, once settings have been verified				
<input type="checkbox"/> Parent/Guardian has permission to increase/decrease insulin correction dose by +/- one (1) unit to three (3) units of insulin or adjust the CHO ratio by +/- 20 grams of CHO per one (1) unit of insulin				
Independent Insulin Administration Skills* & Supervision Needs <span style="float: right;">*Skills to be verified by school nurse</span>				
<input type="checkbox"/> Insulin dose calculations	<input type="checkbox"/> Carbohydrate counting	<input type="checkbox"/> Measuring insulin	<input type="checkbox"/> Insulin administration	
<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	
<input type="checkbox"/> With Supervision	<input type="checkbox"/> With Supervision	<input type="checkbox"/> With Supervision	<input type="checkbox"/> With Supervision	
Other Diabetes Medication				
Name of Medication	Time	Dosage	Route	Possible Side Effects
Authorizations				
<b>HEALTH CARE PROVIDER AUTHORIZATION</b>			<b>PARENT/GUARDIAN AUTHORIZATION</b>	
I authorize the administration of the medications and student diabetes self-management as ordered above.			<p style="text-align: center;"><b>By signing below, I authorize:</b></p> <ul style="list-style-type: none"> <li>The designated school personnel to administer the medication and treatment orders as prescribed above.</li> </ul> <p style="text-align: center;"><b>By signing below, I agree to:</b></p> <ul style="list-style-type: none"> <li>Provide the necessary diabetes management supplies and equipment; and</li> <li>Notify the nurse of any changes in my child's care or condition.</li> </ul>	
<b>Provider Name (PRINT):</b>				
<b>Phone:</b>	<b>Fax:</b>			
<b>Provider Signature:</b>		<b>Date:</b>		
<b>Acknowledged and Received by:</b>			<b>Parent/Guardian Signature:</b>	<b>Date:</b>
			<b>School Nurse:</b>	<b>Date:</b>

**Maryland Diabetes Medical Management Plan / Health Care Provider Order Form**

Valid from: Start \_\_\_/\_\_\_/\_\_\_ to End \_\_\_/\_\_\_/\_\_\_ or for School Year \_\_\_\_\_

<b>Student Name:</b> _____		<b>D.O.B.:</b> _____
<b>Blood Glucose Monitoring*</b> *Self-management skills to be verified by school nurse		
<b>Blood Glucose (BG) Monitoring:</b>		
<input type="checkbox"/> Before meals <input type="checkbox"/> Before PE/Activity <input type="checkbox"/> After PE/Activity <input type="checkbox"/> Prior to dismissal <input type="checkbox"/> Additional monitoring per parent/guardian request <input type="checkbox"/> For symptoms of hypo/hyperglycemia and any time the student does not feel well <input type="checkbox"/> <b>Student may independently check BG*</b>		
<b>Continuous Glucose Monitoring</b>		
<input type="checkbox"/> Uses CGM    Make/Model: _____    Is this CGM make/model approved by the FDA for insulin dosing? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Alarms set for: Low _____ mg/dl    High _____ mg/dl    <input type="checkbox"/> If sensor falls out at school, notify parent/guardian</b>		
<b>Hypoglycemia Management*</b> *Self-management skills to be verified by school nurse		
<b>Mild or Moderate Hypoglycemia</b> (BG below _____ mg/dl)		
<input type="checkbox"/> <b>Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious &amp; able to swallow</b> <input type="checkbox"/> Suspend pump for BG < _____ mg/dl and restart pump when BG > _____ mg/dl <input type="checkbox"/> Student should consume a meal or snack within _____ minutes after treating hypoglycemia <input type="checkbox"/> Other: _____		
<b>Always treat hypoglycemia before the administration of meal/snack insulin</b>		
<b>Repeat BG check 15 minutes after use of quick-acting glucose</b>		
<ul style="list-style-type: none"> <li>• If BG still low, re-treat with 15 grams quick-acting CHO as stated above</li> <li>• If BG in acceptable range and it is lunch or snack time, have student eat and cover meal CHO per orders</li> <li>• If CGM in use and BG ≥70 mg/dL and arrow going up, no need to recheck</li> </ul>		
<b>Student may self-manage mild or moderate hypoglycemia and notify the school nurse*:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Severe Hypoglycemia</b> (includes any of the following symptoms):		
<ul style="list-style-type: none"> <li>• Unconsciousness                      • Semi-consciousness                      • Inability to control airway</li> <li>• Inability to swallow                      • Seizing                      • Worsening of symptoms despite treatment/retreatment as above</li> </ul>		
<input type="checkbox"/> <b>GLUCAGON</b> injection: <input type="checkbox"/> 1 mg <input type="checkbox"/> 0.5 mg IM or Sub-Q		
<ul style="list-style-type: none"> <li>• Place student in the recovery position</li> <li>• Suspend pump, if applicable, and restart pump at BG &gt; _____ mg/dl</li> <li>• Call 911 and state glucagon was given for hypoglycemia; notify parent/guardian</li> </ul>		
<input type="checkbox"/> <b>If glucagon is not available or there is no response to glucagon, administer glucose gel inside cheek, even if unconscious or seizing.</b>		
<b>If glucose gel is administered, place student in recovery position.</b>		
<b>Hyperglycemia Management*</b> *Self-management skills to be verified by school nurse		
<b>If BG greater than _____ mg/dl, or when child complains of nausea, vomiting, and/or abdominal pain, check urine/blood for ketones</b>		
If urine ketones are <b>trace to small</b> or blood ketones less than _____ mmol/L:		
<ul style="list-style-type: none"> <li>• Give _____ ounces of sugar-free fluid or water per hour as tolerated</li> <li>• Give insulin as listed in insulin orders <b>no more than every _____ hour(s)</b></li> </ul>		
If urine ketones are <b>moderate to large</b> or blood ketones greater than _____ mmol/L:		
<ul style="list-style-type: none"> <li>• Give _____ ounces of sugar-free fluid or water per hour as tolerated</li> <li>• If student uses pump, disconnect pump</li> <li>• Give insulin as listed in insulin orders <b>no more than every _____ hour(s) by injection</b></li> </ul>		
<b>If large ketones and vomiting or large ketones and other signs of ketoacidosis, call 911. Notify parent/guardian.</b>		
Re-check BG and ketones _____ hours after administering insulin		
Contact parent/guardian for: <input type="checkbox"/> BG > _____ mg/dl <input type="checkbox"/> Ketones > _____ mmol/L		
<b>Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse: *</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Ketone Coverage</b>		
<b>For ketones <u>trace to small</u> (urine)/&lt; _____ mmol/L (blood):</b>		
<input type="checkbox"/> Correction dose plus _____ unit(s) of insulin <input type="checkbox"/> _____ unit(s) of insulin		
<b>For ketones <u>moderate to large</u> (urine)/&gt; _____ mmol/L (blood):</b>		
<input type="checkbox"/> Correction dose plus _____ unit(s) of insulin <input type="checkbox"/> _____ unit(s) of insulin		
<b>Parent/Guardian Name:</b> _____	<b>Signature:</b> _____	<b>Date:</b> _____
<b>Provider Name:</b> _____	<b>Signature:</b> _____	<b>Date:</b> _____
<b>Acknowledged and Received by:</b> _____	<b>School Nurse:</b> _____	<b>Date:</b> _____

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<b>Student Name:</b>		<b>D.O.B.:</b>
<b>Physical Education, Physical Activity, and Sports*</b> *Self-management skills to be verified by school nurse		
<input type="checkbox"/> Avoid physical education/physical activity/sports if: <input type="checkbox"/> BG < _____ mg/dl <input type="checkbox"/> BG > _____ mg/dl <input type="checkbox"/> Trace/small ketones present <input type="checkbox"/> Moderate/large ketones present <input type="checkbox"/> If BG is ≤ _____ mg/dl, give 15 grams of CHO and return to physical education/physical activity/sports <input type="checkbox"/> May disconnect pump for physical education/physical activity/ sports <input type="checkbox"/> Student may set temporary basal rate for physical education/physical activity/sports* <input type="checkbox"/> Other: _____		
<b>Transportation*</b> *Self-management skills to be verified by school nurse		
<input type="checkbox"/> Check BG prior to dismissal <input type="checkbox"/> If BG is not > _____ mg/dl, give _____ grams carbohydrate snack <input type="checkbox"/> BG must be > _____ mg/dl for bus ride/walk home <input type="checkbox"/> Only check BG if symptomatic prior to bus ride/walk home <input type="checkbox"/> Allow student to carry quick-acting glucose for consumption on bus, as needed for hypoglycemia* <input type="checkbox"/> Student must be transported home with parent/guardian if (specify): _____ <input type="checkbox"/> Other: _____		
<b>Disaster Plan (if needed for lockdown, 72-hour shelter in place)</b>		
<input type="checkbox"/> Continue to follow orders contained in this medical management plan <input type="checkbox"/> Additional insulin orders as follows: unit(s)/hour <input type="checkbox"/> Other: _____		
<b>Pump Management</b>		
Type of Pump:	Pump start date:	Child Lock: <input type="checkbox"/> On <input type="checkbox"/> Off
Basal rates: _____ unit(s)/hour      _____ AM/PM                      _____ unit(s)/hour      _____ AM/PM _____ unit(s)/hour      _____ AM/PM                      _____ unit(s)/hour      _____ AM/PM _____ unit(s)/hour      _____ AM/PM                      _____ unit(s)/hour      _____ AM/PM		
Additional Hyperglycemia Management: <input type="checkbox"/> If BG > _____ mg/dl and has not decreased over _____ hours after bolus, consider infusion site change. Notify parent/guardian <input type="checkbox"/> For infusion site failure: <input type="checkbox"/> Give insulin via syringe or pen <input type="checkbox"/> Change infusion site <input type="checkbox"/> For suspected pump failure, suspend or remove pump and give insulin via syringe or pen <input type="checkbox"/> If BG > _____ mg/dl and <u>moderate to large</u> ketones, student should change infusion site and give correction dose by pen or syringe <input type="checkbox"/> Comments: _____		
<b>Independent Pump Management Skills and Supervision Needs*</b>		
*Skills to be verified by school nurse. Supervision will be provided if not fully independent when appropriate		
<b>Student is independent in the pump skills indicated below:</b>		
<input type="checkbox"/> Carbohydrate counting <input type="checkbox"/> Reconnect pump at infusion set <input type="checkbox"/> Give self-injection if needed	<input type="checkbox"/> Bolus an insulin dose <input type="checkbox"/> Prepare and insert infusion set <input type="checkbox"/> Disconnect pump	<input type="checkbox"/> Set a basal rate/temporary basal rate <input type="checkbox"/> Troubleshoot alarms and malfunctions <input type="checkbox"/> Other: _____
<b>Additional Orders</b>		
<input type="checkbox"/> Please FAX copies of BG/insulin diabetes management records every _____ weeks (FAX number: _____ )		
<input type="checkbox"/> Other orders: _____		<i>Use page 4 of form if additional space is needed</i>
<b>Parent/Guardian Consent for Self-Management</b>		
<ul style="list-style-type: none"> <li>▪ I acknowledge that my child <input type="checkbox"/> <b>is</b>    <input type="checkbox"/> <b>is not</b> authorized to self-manage as indicated by my child's health care provider</li> <li>▪ I understand the school nurse will work with my child to learn self-management skills if he/she is not currently capable of or authorized to perform independently</li> </ul>		
<b>My child has my permission to independently perform the diabetes tasks listed below as indicated by my child's health care provider:</b>		
<input type="checkbox"/> Blood glucose monitoring <input type="checkbox"/> Carbohydrate counting	<input type="checkbox"/> Insulin administration <input type="checkbox"/> Insulin dose calculation	<input type="checkbox"/> Pump management <input type="checkbox"/> Other: _____
<b>Parent/Guardian Name:</b>	<b>Signature:</b>	<b>Date:</b>
<b>Provider Name:</b>	<b>Signature:</b>	<b>Date:</b>
<b>Acknowledged and Received by:</b>	<b>School Nurse:</b>	<b>Date:</b>

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<b>Student Name:</b>	<b>D.O.B:</b>
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**Additional Orders Addendum**

<b>Parent/Guardian Name:</b>	<b>Signature:</b>	<b>Date:</b>
<b>Provider Name:</b>	<b>Signature:</b>	<b>Date:</b>
<b>Acknowledged and received by:</b>	<b>School Nurse:</b>	<b>Date:</b>