Diabetes Medication Management Orders In Accordance with UCA 53A-11-603 and 53A-11-604 Utah Department of Health/Utah State Board of Education	PCH Outpatient Diabetes Program (801) 213-3599 Fax (801) 587-7539	Other Provider (LIP)

STUDENT INFORMATION	School Year:	
Student Name:	☐ Type 1 ☐ Type 2	Name of School:
DOB:	Age at diagnosis:	School Fax:

In accordance with these orders, an Individualized Healthcare Plan (IHP) must be developed by the School Nurse, Student, and Parent to be shared with appropriate school personnel, *and cannot be shared with any individual outside of those public education employees without parental consent.* As the student's Licensed Independent Provider (LIP), I confirm the student has a diagnosis of diabetes mellitus and it is 'medically appropriate for the student to possess and self-administer diabetes medication and the student should be in possession of diabetes medications at all times'. Per my assessment, I recommend:

☐ Student is capable to carbohydrate count meals and snacks for insulin adjustment, carry, and self-administer diabetes medication/insulin.

☐ Student requires a trained adult to supervise carbohydrate counting of meals and snacks for insulin adjustment and self-administration of diabetes medication/insulin.

☐ Student requires a trained adult to carbohydrate count meals and snacks, for insulin calculation, and administer diabetes medication/insulin during periods the student is under the control of the school.

☐ This student may participate in ALL school activities, including sports and field trips, without restriction.

☐ This student may participate in school activities with the following restrictions:

EMERGENCY GLUCAGON ADMINISTRATION Immediately for severe hypoglycemia: unconscious, semiconscious (unable to control airway, or seizing	Glucagon Dose: 1.0 mg/1.0 ml	Route: IM	Possible side effects: Nausea and Vomiting

BLOOD GLUCOSE TESTING Target range for blood glucose (BG): ☐100-200 ☐80-150 ☐Other:

Times to test: ☐Before meals ☐Before exercise ☐After exercise ☐Before going home

☐If symptomatic (See student's specific symptoms in Individualized Healthcare Plan (IHP).

- If BG is less than ____ mg/dl, follow management per Diabetes Emergency Action Plan (EAP).
- Student should not exercise if BG is below ____ mg/dl or symptomatic of hyperglycemia.

SNACKS ☐15 gram carb snack at ___ AM ☐ 15 gram carb snack at ____ PM ☐No routine snacks at school
☐15 gram carb snack before PE/Recess ☐'Free' snacks (no insulin coverage) ☐Other:

INSULIN ADMINISTRATION	☐Humalog ☐Novolog ☐Apidra ☐Other:	☐Insulin vial/syringe ☐Insulin pen ☐Insulin pump	Route: Subcutaneous	Possible side effects: Hypoglycemia

Insulin to Carbohydrate (I:C): ___ units for every ___ grams of carbohydrate before food.	Correction Dose (can only be administered at meal times):___ unit for every ____ mg/dl for blood glucose above ___mg/dl.

SNACKS/PARTIES: ☐Snacks/parties (use I:C ratio) ☐No coverage for snacks/parties ☐Other:

INSULIN PUMP: If using insulin pump, carbohydrate ratio and correction dose are calculated by pump. Correction doses at times other than meals per PUMP calculation ONLY.

ADDITIONAL PUMP ORDERS: Student may be disconnected from pump for a maximum of 60 minutes, or per IHP/EAP. If unable to use pump after 60 minutes contact parent/guardian, and if BG is over 250 mg/dl give correction dose via syringe or pen. If able to reconnect pump, administer correction dose as calculated by pump.

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Student Name:	**DOB:**

ADDITIONAL ORDERS:

☐None

☐Student to go to office for adult supervision of BG testing and insulin administration

☐The Dexcom G5 is the only Continuous Glucose Monitor (CGM) FDA approved for insulin dosing based on glucose values. Correction doses can be determined based on the CGM if the sensor glucose value is between 80-250 mg/dl, and there are no double arrows up or down. In addition, the parent/guardian must sign below verifying they are responsible for calibrating the CGM at home and approve the school personnel or school nurse to dose from the CGM.

Parent/Guardian Signature (for Dexcom G5 only):

TO BE COMPLETED BY PARENT OR GUARDIAN

I understand that a school team, including parent or guardian, may make decisions about implementation and assistance in the school based on consideration of the above recommendation, available resources, and the student's level of self-management. I acknowledge that these orders signed by the LIP will be used by the school nurse, and shared with appropriate school staff, to develop the IHP for my child's diabetes management at school. I understand and accept the risk that in the course of communication between myself, the school, and the provider, protected health information (PHI) sent via unencrypted email or text message may be intercepted and read by third parties.

Date: Parent/Guardian Signature:	Best contact information:	Emergency contact: Name: Cell:
Date: Physician Signature (LIP):	Physician (LIP) Name:	Physician (LIP) Phone: