DIABETIC MANAGEMENT GUIDELINES

CONESTOGA VALLEY SCHOOL DISTRICT

STUDENT NAME: _____ GRADE: _____ DATE: _____

#1 Contact _____ Relationship to student: _____

(H) _____ C) _____ (W) _____

#2 Contact _____ Relationship to student: _____

(H) _____ C) _____ (W) _____

HEALTHCARE PROVIDER: _____ Phone: _____ Fax: _____

INSULIN COVERAGE DURING SCHOOL HOURS:

_____ **Scheduled insulin administration times: _____**

_____ **Scheduled insulin administration with syringe or pen:**

Administer: _____units of _____ insulin SQ for blood sugar > _____
_____units of _____ insulin SQ for blood sugar > _____
_____units of _____ insulin SQ for blood sugar > _____
_____units of _____ insulin SQ for blood sugar > _____
_____units of _____ insulin SQ for blood sugar > _____
_____units of _____ insulin SQ for blood sugar > _____
_____units of _____ insulin SQ for blood sugar > _____

_____ **Above dose may be repeated every ___ hours**

_____ **Scheduled insulin administration for a pump:**

Type of insulin used:_____
Correction Factor: _____ units for every _____mg/dl above_____
Coverage factor: _____units for every _____carbohydrates

_____ Student can give own insulin independently via (specify): syringe pump pen
_____ Student requires supervision/ assistance in insulin administration (specify): syringe pump pen

Current insulin regimen at home:_____

Additional information: _____
_____
_____

HYPOGLYCEMIA/ GLUCAGON TREATMENT:

_____**Treat all blood sugars < _____mg/dl with _____ grams of rapid acting carbohydrate (specify): _____**

_____ **If no improvement of symptoms within _____ minutes:**
_____repeat treatment _____re-test blood sugar

_____**GLUCAGON _____ mg IM/SQ if student is unconscious or having seizures due to hypoglycemia**

(See Other Side)

BLOOD GLUCOSE TESTING:

_____ For signs and symptoms of high/ low blood sugar as needed

_____ Daily before lunch

_____ Other (specify) _____

_____ Notify parents immediately for blood sugar < _____ and > _____

_____ Restrict physical education/sports/recess for blood glucose < _____ and > _____

URINE KETONE TESTING:

_____ For blood sugar > _____

_____ For acute illness with vomiting or fever

_____ Notify parents immediately for _____ ketones

for transport to E.R.)

_____ Other (specify) _____

_____ Restrict physical education/sports/recess for _____ ketones

ACTIVITY:

_____ No restrictions

_____ Restrict physical education/sports/recess for _____

_____ If exercise is more than _____ hours after a snack/ meal, a snack consisting of:

(specify)_____should be consumed prior to exercise

_____ Other _____

STUDENT'S USUAL HIGH/LOW BLOOD SUGAR SYMPTOMS (Indicate with "H" or "L"):

___ Hungry
___ Pale, perspiring, shaking
___Eyes appear glassy
___ Pale or flushed face
___ Other _____

___ Headaches
___ Inattentive, drowsy, sleepy
___ Weak, irritable, confused
___ Speech/coordination change

___ Personality changes
(i.e.: crying ,stubbornness)
___ If not treated, loss of consciousness and/or seizure

HEALTHCARE PROVIDER SIGNATURE: _____

PARENT SIGNATURE: _____

DURATION OF ORDERS: _____ - _____ SCHOOL YEAR