Gaston County School Nursing Program
Physician's Orders and Treatment Plan Type I Diabetes - No Pump

Date:			
Student Name:		**DOB:**	
Teacher/Grade:		**Bus:**	
Parent/Guardian Name:		**Phone:**	
Emergency Contact:		**Phone:**	
Physician's Name:		**Phone:**	

BLOOD SUGAR MONITORING

Target range of blood sugar: ____to____Type of Meter_____.

What help needed with blood sugar testing? _____ Times to test: _____.
Call parent if blood sugar is higher than ____ or lower than ____.

INSULIN AND ORAL MEDICATIONS

Oral diabetes medication: _____ Dose:_____Time to be given:_____.

Insulin Type: _____ Dose: _____ Time to be given: _____.

Insulin/carbohydrate ratio for meals/snacks:____. insulin units for every ____.gms. of carbohydrates eaten.
(Parent/guardian authorized to increase or decrease insulin to carbohydrate ratio within the following range:
1 unit per prescribed grams of carbohydrates +/- 5 grams of carbohydrates. YES NO)

Also correct for high blood sugar using the following sliding scale (may be used every 2 hours):
Blood Sugar Range _____ mg/dl Administer _____ units
Blood Sugar Range _____ mg/dl Administer _____ units
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Blood Sugar Range _____ mg/dl Administer _____ units
Blood Sugar Range _____ mg/dl Administer _____ units

Parent/guardian authorized to increase or decrease sliding scale within +/- 2 units of insulin. YES NO

Does student know how to:

Give own injection? YES NO *Draw up correct insulin dose?* YES NO
Determine correct insulin dose? YES NO *Handle and dispose of needles safely?* YES NO

TREATMENT FOR HIGH BLOOD SUGAR (HYPERGLYCEMIA)

Student Name:		DOB:	

To correct high blood sugar, give insulin: ____ units for every ____ mg/dl over____.
Correction times:____ **Do not correct more frequently than every ____ hours.**

Check for urine ketones if blood sugar is above _____, or if student has nausea & vomiting.
Check blood sugar again in _____ and at _____ intervals.

TREATMENT FOR LOW BLOOD SUGAR (HYPOGLYCEMIA)

Type and amount of fast sugar to be given: _____.

If symptoms do not improve in _____ minutes, give fast sugar again.

When symptoms improve, provide an additional snack of _____.
Check blood sugar level every _____ minutes until it is above _____.

Give glucagon (if ordered) if student becomes unconscious, has a seizure or is unable to swallow.
Glucagon ordered? YES NO Glucagon dosage: _____.

FOOD AND EXERCISE

Recommended carbohydrates for meals: _____ Snacks: _____.
Student should not exercise if blood sugar is below _____ mg/dl or above _____. mg/d, or if student has ketones.

Signatures

My signature below provides authorization for the above written orders and will assist the school nurse in developing an Individualized Health Plan. I understand that all procedures will be implemented in accordance with physician's orders, state laws, and regulations and may be performed by appropriately trained staff.

Physician Signature: _____ **Date:** _____

Reviewed by:

Parent Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____