

Student Name				Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth ____/____/____ Month / Day / Year
ID Number	DOE District	School	Grade	Class	Borough
School Address					ZIP Code

EMERGENCY SITUATIONS		Diagnosis <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Other:
Severe Hypoglycemia <input type="checkbox"/> Give Glucagon AND CALL 911 PRN for unconsciousness, unresponsiveness, seizure, or inability to swallow EVEN if the bG is unknown. Turn onto left side to prevent aspiration.	Risk for Diabetic Ketoacidosis (DKA) <input type="checkbox"/> Ketones: Test ketones if hyperglycemic*, vomiting, or fever ≥100.5 If small or trace, give water. Re-test ketones and bG in ____ hours If moderate or large, give water and: <input type="checkbox"/> Call parent and/or MD <input type="checkbox"/> No Gym <input type="checkbox"/> If vomiting, unable to take PO, and MD not available, CALL 911. <input type="checkbox"/> Give insulin, if ordered below	Blood Glucose Monitoring and Insulin Orders Student: <input type="checkbox"/> May check bG without supervision <input type="checkbox"/> May give insulin without supervision <input type="checkbox"/> May check bG with supervision <input type="checkbox"/> May give insulin with supervision <input type="checkbox"/> Must have school personnel check bG <input type="checkbox"/> Must have school nurse give insulin

	<input type="checkbox"/> Lunch	<input type="checkbox"/> Snack	<input type="checkbox"/> Gym	<input type="checkbox"/> PRN
Hypoglycemia	For bG < ____ mg/dL Give ____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in ____ minutes; if bG < ____, repeat carbs and re-check until bG > ____ . THEN <input type="checkbox"/> Give insulin, BEFORE Lunch <input type="checkbox"/> Give insulin AFTER Lunch	For bG < ____ mg/dL Give ____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in ____ minutes; if bG < ____, repeat carbs and re-check until bG > ____ . THEN <input type="checkbox"/> Give insulin BEFORE Snack <input type="checkbox"/> Give insulin AFTER Snack	For bG < ____ mg/dL Give ____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in ____ minutes; if bG < ____, repeat carbs and re-check until bG > ____ . <input type="checkbox"/> If initial bG < ____, No Gym <input type="checkbox"/> Give Snack AFTER treatment THEN send student to Gym	For bG < ____ mg/dL Give ____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in ____ minutes; if bG < ____, repeat carbs and re-check until bG > ____ . <input type="checkbox"/> Give Snack after treating Hypoglycemia
Between Hypo- and Hyperglycemia	<input type="checkbox"/> Give insulin BEFORE Lunch <input type="checkbox"/> Give insulin AFTER Lunch	<input type="checkbox"/> Give insulin BEFORE Snack <input type="checkbox"/> Give insulin AFTER Snack	<input type="checkbox"/> Give Snack BEFORE Gym <input type="checkbox"/> Send to Gym	
Hyperglycemia* bG > ____	<input type="checkbox"/> Test ketones if bG > ____ mg/dL Treat as per Risk for DKA above <input type="checkbox"/> Give insulin BEFORE Lunch <input type="checkbox"/> Give insulin AFTER Lunch	<input type="checkbox"/> Test ketones if bG > ____ mg/dL Treat as per Risk for DKA above <input type="checkbox"/> Give insulin BEFORE Snack <input type="checkbox"/> Give insulin AFTER Snack	<input type="checkbox"/> Test ketones if bG > ____ mg/dL Treat as per Risk for DKA above For bG > ____ mg/dL No Gym For bG > ____ mg/dL AND at least ____ hours since last insulin, give insulin	<input type="checkbox"/> Test ketones if bG > ____ mg/dL Treat as per Risk for DKA above For bG > ____ mg/dL No Gym For bG > ____ mg/dL AND at least ____ hours since last insulin, give insulin
Carb Coverage Insulin Instructions	<input type="checkbox"/> Carb coverage ONLY <input type="checkbox"/> Carb coverage PLUS Correction Dose when bG > Target bG	<input type="checkbox"/> Carb coverage ONLY <input type="checkbox"/> Carb coverage PLUS Correction Dose when bG > Target bG		

INSULIN ORDERS (CHECK ONE BOX ONLY) Carb Coverage (plus Correction Dose if ordered above) Sliding Scale Carb Coverage plus Sliding Scale for Correction No Insulin at School Glucose Monitoring ONLY

<input type="checkbox"/> Syringe / Pen	Name of Insulin	<input type="checkbox"/> Insulin Pump (Brand & Model)
Target (Single #) bG = ____ mg/dL	Sensitivity Factor (Correction) 1 unit will decrease bG by ____ mg/dL	Insulin:Carb Ratio: (I:C) For LUNCH 1: ____ gms For SNACK 1: ____ gms
Basal Rate(s): ____ units/hour	In School <input type="checkbox"/> Gym ____ %	Temporary basal rate for ____ hours <input type="checkbox"/> Disconnect Pump for gym

Round DOWN the insulin dose to the closest 0.5 units for syringe/pen

$$\text{Carb Coverage} = \frac{\# \text{ gms carb in meal}}{\# \text{ gms carb in I:C}} = \text{____ units insulin}$$

$$\text{Correction Dose} = \frac{\text{bG} - \text{Target bG}}{\text{Sensitivity Factor}} = \text{____ units insulin}$$

Example: Current bG = 250 Target bG=150 Sensitivity Factor = 100 Insulin:Carb ratio = 1:20 Lunch carbs = 60 gms
 Carb Coverage plus Correction Dose Carb Coverage: $\frac{60 \text{ gms carb}}{20} = 3 \text{ units}$ PLUS Correction Dose: $\frac{250-150}{100} = 1 \text{ unit}$ TOTAL DOSE: 3+1=4 units

For Pump:
 Follow Pump recommendation for bolus dose [If not using Pump recommendation, round DOWN the dose down to nearest 0.1 unit]
 For bG > ____ mg/dL that has not decreased ____ hours after correction consider pump failure. Notify parent.
 For suspected pump failure: DISCONNECT pump and give insulin by syringe or pen

SLIDING SCALE Name of Insulin	<input type="checkbox"/> Pre lunch	bG Range	Insulin Units	<input type="checkbox"/> Other time	bG Range	Insulin Units
	_____		_____	_____		_____
<i>Please do NOT overlap ranges (e.g. 100-200, 200-300, etc). If ranges overlap, the lower dose will be given.</i>						

SNACK: Time of day: _____ Type & Amount: <input type="checkbox"/> Student may carry and self administer snacks	HOME MEDICATIONS Insulin (Dose, Frequency, and Time) _____ Oral Medications (Dose, Frequency, and Time) _____	OTHER DIABETES ORDERS _____ _____
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Health Care Practitioner Name (Please Print)	Tel. No.	For DOHMH USE: Revisions per consult with Prescriber:
Health Care Practitioner Signature	Date _____/_____/_____ Fax No.	
Address	NYS Lic. No. (Required)	