Insert name and address of Institution:	**Utah Department of Health/Utah Office of Education** **Licensed Independent Provider's (LIP)** **Diabetes Medication/Management Orders** **In Accordance with Utah Code 53G-9-504 and 53G-9-506**

STUDENT INFORMATION

Name or Label:	Name of School:	School Fax:	For School Year:
Date of Birth:	☐Type 1 Diabetes ☐Type 2 Diabetes	Age at diagnosis:	

TO BE COMPLETED BY LIP

In accordance with these orders, an Individualized Health Care Plan (IHCP) 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 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 medication at all times.

☐ It is medically appropriate for the student to possess, but NOT self-administer diabetes medication and the student should be in possession of diabetes medication at all times.

☐ It is NOT medically appropriate for the student to possess or self-administer diabetes medication and the student should have access to their diabetes mediation at all times.

Per my assessment, I recommend:

☐ Student is capable to independently count carbohydrates at meals and snacks for insulin administration.
☐ Student requires a trained adult to supervise carbohydrate counting of meals and snacks for insulin administration.
☐ Student requires a trained adult to carbohydrate count meals and snacks and administer insulin.
☐ This student may participate in ALL school activities, including sports and field trips, with the following restrictions:

PROCEDURES

Emergency Glucagon Administration Immediately for severe hypoglycemia: unconscious, semi-conscious (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) is: ☐100 to 200 ☐ 80 to 150 ☐ Other:__________

☐ Before Meals ☐ Before Exercise ☐ After Exercise ☐ Before going home ☐ Other

☐ **If symptomatic (See student's specific symptoms in Individualized Health Care Plan, IHCP)**

☐ **If BG is less than _______, follow management per Diabetes Emergency Action Plan (page 2)**

☐ Student should not exercise if BG is below ______ mg/dl, or symptomatic of hyperglycemia.

"Free" Snacks (no insulin coverage)

☐ No routine snacks at school ☐ 15 gram carb snack at ____ am and/or ____ pm ☐ 15 gram carb snack before PE ☐ Other:_____

Insulin Administration

☐ Apidra ☐ Humalog ☐ Novolog ☐ Admelog Delivery Device: ☐ Insulin Vial/Syringe ☐ Insulin Pen ☐ Insulin Pump	**Route:** **Subcutaneous**	Possible side effects: Hypoglycemia

☐ Insulin to Carbohydrate Ratio (I:C): ______ unit for every ______grams of carbohydrate before meals

☐ Correction Dose only to be administered at meal times: _____ unit for every ______ mg/dl for blood sugars above ______ mg/dl

When to give Insulin:

Snacks (special occasions/parties): ☐ No coverage for snacks ☐ Use I:C ratio ☐ Contact parent/guardian

If using insulin pump, carbohydrate ratio and correction dose are calculated by pump. These doses are provided as information for special circumstances. Basal insulin for pump use:

_____am/pm : _____units per hour; _____am/pm : _____units per hour; _____am/pm : _____units per hour
_____am/pm : _____units per hour; _____am/pm : _____units per hour; _____am/pm : _____units per hour

Additional Pump Orders:

- Student may be disconnected from pump for a maximum of 60 minutes, or per Diabetes Emergency Action Plan.
- If unable to use pump after 60 minutes contact parent/guardian, and if BG is over 250 mg/dl give correction dose via syringe.
- If able to re-connect pump, administer correction dose as calculated by pump.

Additional Orders ☐ Yes ☐ No ☐ See attached

Continuous Glucose Monitor: ☐ Dexcom ☐ Medtronic Guardian ☐ Freestyle ☐ Other Version being used:

Licensed Health Care Provider Signature:	Date:	Office:	Fax:

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 recommendations, 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 and IHCP for my child's diabetes management at school. If my child is using a CGM at school I understand that I am responsible for calibrating the CGM at home, if required, and that I approve the school personnel or school nurse to make treatment decisions based on the information from the CGM.

Parent/Guardian signature:	Date:	Best contact information:	**Emergency contact** Name:______________________ Cell: ______________________