COLONIAL SCHOOL DISTRICT
MEDICAL ORDERS FOR DIABETES CARE AT SCHOOL

PATIENT'S NAME DATE OF BIRTH

1. Check blood sugar before lunch and as needed. Watch for low blood sugar reactions, hypoglycemia, as evidenced by headaches, shakiness, dizziness, sweating, sudden hunger or sleepiness after gym or other activities.
2. If the child has symptoms of hypoglycemia, check blood sugar and follow guidelines below:

IF BELOW mg/dl	**IF mg/dl**	**IF ABOVE mg/dl**
1. Give 15 grams of carbohydrate* and send to lunch if lunchtime unless symptomatic. 2. If symptomatic, wait 15 minutes and retest. 3. If blood sugar < 80, give another 15 grams of carbohydrate. **SEVERE REACTION:** (seizures, loss of consciousness, confusion or unable to eat/drink) a. Give 1 mg (1 cc) Glucagon SQ/IM. **OR** b. Rub cake icing or glucose gel in mouth. **THEN** c. When awake, give 15 grams of carbohydrate*.	Child may return to class or go to eat lunch. **INSULIN OR OTHER INSTRUCTIONS:** (Use only if directed by parent) **PUMP INSTRUCTIONS:** ***examples of 15 grams of carbohydrate** 4 ounces fruit juice or regular soda 8 ounces of milk	1. Check urine for ketones. 2. If ketones are negative, encourage sugar-free fluids and send child to class or lunch. 3. If ketones are positive: a. **Call Parents.** b. Give one ounce of sugar-free fluid per year of age (eg. 8 oz. /hour for an 8 year old). **KETONE INSULIN DOSE:** (use only if directed by parents) 4. If ketones are large, if child is vomiting, or very sick, call parents immediately to pick up child. (Contact CHOP Diabetes Center 215-590-3174 ONLY if parent is unavailable).

(Adapted from L.Travis, et al.:Diabetes Mellitus in Children & Adolescents, Philadelphia: W.B. Saunders Co. 1995)

Physician/Health Care Provider's Signature Date

Parental Permission

The Diabetes Center for Children considers the school a member of the Diabetes Team in caring for your child.

I _____, parent/guardian of _____

_☐_ Release Information to my child's school via phone or fax in relation to Diabetes Management.

_☐_ Obtain Information from my child's school for the purpose of Diabetes Management for my child.

Name of School _____

In an urgent diabetes-related situation, if the school is unable to reach my designated emergency contact person, or me the Diabetes Center is permitted to give advice to school personnel for necessary and immediate treatment.

Parent/Guardian's Signature Date

School Nurse's Signature Date