ALPHA ACADEMY

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DIABETES CARE PLAN
Physician's Orders for Student with Diabetes

Rev. 06/2022

Student _____ DOB _____ School _____ Grade _____

Parent/Guardian _____ Phone _____ Phone _____

Home Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone _____ Phone _____

Physician _____ Office _____ FAX _____

Child has ☐ Type I or ☐ Type II Child's Blood Sugar Target Range: > _____ mg/dl to < _____

When to Monitor Blood Sugar:

☐ before breakfast	☐ before lunch	☐ before snack	☐ before PE/exercise
☐ after breakfast	☐ after lunch	☐ after snack	☐ after PE/exercise
☐ before going home	☐ as needed for signs/symptoms of low or high blood sugar		

If child has a CGM and is symptomatic, confirm with finger stick.

What diabetes medications to be given at school:

☐ Apidra	☐ Humalog	☐ Novolog	☐ Metformin
☐ Glucose tabs	☐ Glucagon	☐ Other: _____	

Method of insulin delivery during school hours:

☐ Insulin Pump: ☐ Animas ☐ Medtronic ☐ OmniPod ☐ t:slim

Insulin to carbohydrate ratio:	Insulin sensitivity factor:	Basal Settings Time	Basal Settings Units/Hours
Breakfast 1 unit per _____ grams/carbs	Breakfast 1 unit per _____ points > _____		
Lunch 1 unit per _____ grams/carbs	Lunch 1 unit per _____ points > _____		
Snack 1 unit per _____ grams/carbs	Snack 1 unit per _____ points >		

☐ Vial/Syringe ☐ Insulin Pen

Carbohydrate Counting (use rapid acting insulin)	**Insulin Sensitivity Factor**	**Sliding Scale** (use rapid acting insulin)
1 unit per _____ grams/carbs ☐ meals/snacks	Target blood sugar: _____	**Target Range**:
	Insulin sensitivity factor: _____	100-149 Give _____ units
☐ Fix dose { Breakfast _____ units		150-199 Give _____ units
Lunch _____ units	1 unit per _____ points > _____	200-249 Give _____ units
Dinner _____ units		250-299 Give _____ units
Snacks _____ units		300-349 Give _____ units
	Current BS - Target BS / Insulin sensitivity factor = Number of Units	350-399 Give _____ units
Insulin must be given anytime the child eats carbs, except in the case when treating a low blood sugar.		400-449 Give _____ units
	Sensitivity factor may not be given more frequently than every 2 hours due to the risk of low blood sugar.	450-499 Give _____ units
		> 500 Give _____ units
Inject insulin { ☐ before eating ☐ after eating		Other Give _____ units

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Blood sugar (BS) at which parent/guardian should be notified:
LOW < _____ mg/dl or HIGH > _____ mg/dl.

HYPOGLYCEMIA	HYPERGLYCEMIA
Do not send student unaccompanied to the office if symptomatic or blood sugar (BS) < 70mg/dl.	If blood sugar (BS) >300mg/dl with ketones or 2 consecutive unexplained BS >250 mg/dl (with or without ketones), i.e. malfunctioning pump the student may require insulin via injection and/or new infusion site/set.
➢ Test blood sugar and treat symptoms. If blood glucose meter is not available treat symptoms per care plan guidelines.	➢ First contact parent/guardian, if not available call school nurse who will call health care provider for further instructions.
➢ Blood sugar < 70mg/dl and/or symptomatic: treat with 10 to 15 grams carbohydrate snack (juice, sugar tabs, etc.) and recheck BS in 15 minutes.	➢ An order for insulin specific to the incident may be faxed from the health care provider.
➢ Mild symptoms: treat with snack, juice, sugar tabs, etc., recheck and repeat every 15 minutes until BS> 70mg/dl, then give snack with protein or lunch.	➢ Check urine ketones if BS > _____mg/dl. and recheck in 1 hour.
➢ Moderate symptoms: if able to swallow, administer glucose gel, frosting, etc. Repeat until BS is above 70mg/dl, then give snack with protein or lunch.	➢ If trace/moderate ketones are present call parent/ guardian, provide water and student should remain under medication clerk observation until ketones clear.
➢ Call 911: if severe symptoms (which may include seizures, unconscious) or unable/unwilling to take gel or juice: administer Glucagon _____ mg(s) by intramuscular or intranasally injection and contact parent/guardian.	➢ Student will be sent home from school when ketones are large or shows symptoms of nausea, vomiting, tired, thirsty, dry mouth, difficulty breathing, fruity breath, or confused. Call 911 if severe symptoms persist.

Student's Self Care: The ability level is determined by health care provider with input from school nurse & parent/guardian.

Totally independent management	☐Yes	☐No	☐N/A	Self-injects with trained staff supervision	☐Yes	☐No	☐N/A
Tests independently	☐Yes	☐No	☐N/A	Injections to be done by trained staff	☐Yes	☐No	☐N/A
Needs verification of BS by staff	☐Yes	☐No	☐N/A	Self-treats mild hypoglycemia	☐Yes	☐No	☐N/A
Assist/testing to be done by trained staff	☐Yes	☐No	☐N/A	Monitors own snacks and meals	☐Yes	☐No	☐N/A
Administers insulin independently	☐Yes	☐No	☐N/A	Independently counts carbohydrates	☐Yes	☐No	☐N/A
Self-injects with verification of dose	☐Yes	☐No	☐N/A	Tests and interprets urine/blood ketones	☐Yes	☐No	☐N/A

Children with Disabilities: It is and shall remain the policy of Alpha Academy not to discriminate on the basis of gender or disability in its educational programs, activities, or employment policies as required by Title IX of the 1972 Educational Amendments, the 1990 Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973. It is the policy of Alpha Academy to provide equal employment opportunities on a nondiscriminatory basis, regardless of sex, race, age, national origin, disability or religion. The individual designated to ensure district compliance with Section 504 is the Executive Director of Student Services, phone (910) 223-7711, and the mailing address is Alpha Academy, 8030 Raeford Rd, Fayetteville NC 28304.

Does your child have a Section 504 Plan? ☐Yes ☐No	Does your child have an Individual Education Plan (IEP)? ☐Yes ☐No

Release of Liability: Realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, and Alpha Academy of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year. **Parent/Guardian Signature:** **Date:**

MD Stamp Below		
	Physician Signature:	**Date:**
	Principal Signature:	**Date:**
	School Nurse Signature:	**Date:**

Copy: Director of Health Services, 504 Coordinator, EC Case Manager; Public Health School Nurse, Cum. Folder; If applicable cc: Special Needs Nurse, School Bus Driver