MEDICAL ORDER FOR MEDICATION AND TREATMENT IN SCHOOL

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name |  | Date of Birth |  |
| Diagnosis |  | Grade |  | Home Phone |  |
| School |  | Today’s Date |  |
| Health Care Provider |  | Office Phone |  |
|  |
| **Student Pump Skills** | **Needs Assistance?** |
| 1. Independently count carbohydrates. |   |  | **YES** |  | **NO** |
| 2. Give correct bolus for carbohydrates consumed. |  |  | **YES** |  | **NO** |
| 3. Calculate and administer supplemental/correction bolus. |  |  | **YES** |  | **NO** |
| 4. Set temporary basal rate for exercise. |  |  | **YES** |  | **NO** |
| 5. Disconnect pump if needed. |  |  | **YES** |  | **NO** |
| 6. Reconnect pump at infusion set. |  |  | **YES** |  | **NO** |
| 7. Fill reservoir and prime tubing. |  |  | **YES** |  | **NO** |
| 8. Insert new infusion set. |  |  | **YES** |  | **NO** |
| 9. Give injection with syringe, if needed. |  |  | **YES** |  | **NO** |
| 10. Troubleshoot all alarms. |  |  | **YES** |  | **NO** |
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| **Medication & Treatment** | **Dose** | **Time** |
| Blood glucose testing with meter, lancets and strips | NA | Before lunch or any time student does not feel well |
| Urine ketone testing | NA | Any time blood glucose is > 250 or when student is ill – follow emergency plan |
| Glucose tablets, Sweetarts®, LifeSavers®, juice or regular soda | * 2-4 glucose tablets
* 6-9 Sweetarts®
* 4-6 LifeSavers®
* 4-6 oz juice or soda
 | Any time blood glucose is <70 – follow emergency plan |
| Glucagon – injectable | ½ or 1 mg (circle appropriate dose)intramuscularly in leg, arm or buttock | Severe low blood glucose – the student cannot swallow, is unconscious or having a seizure – follow emergency plan |
| Treatment for nausea or vomiting | * Keep student turned on side
* Call 911
* Call parent and physician immediately
 | When student is nauseated or vomiting as a result of side effects of glucagons administration or high urine ketones – follow emergency plan |
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| Specific Duration of Order |  |  |
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| Health Care Provider Signature |  |  |
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| Phone |  |  |
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| *I hereby give permission for the school to administer the medications and treatments as prescribed above. I also give permission for the school to contact the above health care provider regarding the administration of this medication.* |
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| Parent/Guardian Signature | Home Phone |
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|  |  |  |
| Date |  | Work Phone |
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|  |  |  |
|  |  | Other Phone (Cell or Pager) |