



BONNIE CONE LEADERSHIP ACADEMY

DIABETES MEDICAL ORDERS

CAMPUS: _____ SCHOOL YEAR: 20____/20____

STUDENT: _____ GRADE _____ TEACHER _____

BLOOD GLUCOSE TARGET RANGE: _____ mg/dl to _____ mg/dl

Blood Glucose Testing:

☐ independent

☐ needs assistance

____ before AM snack

____ before lunch

____ before after-school sports

____ when student feels low/high or ill

____ other times _____

____ if BG is less than _____ mg/dl or BG is greater than _____, call parent.

Comments: _____

For BG, lower than _____ or over _____ see Hypoglycemia Emergency Care Plan or DMMP

Urine Ketones Testing:

____ For BG greater than _____ mg/dl, do ketone testing.

If ketones are positive, contact parent and encourage sugar-free fluids.

Insulin Injection or Pump Bolus:

☐ independent

☐ needs assistance

Type of Insulin _____

____ Always call parent for dose.

____ Bolus for meal, based on carbohydrate count.

____ Correction or supplemental bolus for high BG

Comments: _____

For Students with Insulin Pump:

Type of pump: _____

Does student need assistance with pump skills?

☐ Yes

☐ No

Comments: _____

Seizure, Unable to Swallow and/or Loss of Consciousness:

____ Glucose gel and **call 911.**

____ Glucose gel, 1 mg of Glucagon IM or SQ and **call 911.**

I give my permission for the school to contact my health care provider, _____, at (____) _____ (phone#) regarding the treatment of my child's diabetes.

Parent/Guardian Signature: _____ Date: _____