LOGOS
PUBLIC CHARTER SCHOOL
Innovative Education Kindergarten to Career
1203 N Ross Ln, Medford, OR 97501 | 541.842.3658

Diabetic Treatment Orders

Student Name:_____ DOB:_____ Grade:_____ Date:_____

Parent/Guardian:_____ Phone:_____

Name of Clinic:_____ Phone:_____

Section 1: Blood Glucose

Target Blood Glucose Range:_____mg/dL.

☐ Student requires supervision, assistance, monitoring of diabetes tasks at school.
☐ Student is independent and able to check blood glucose, interpret results and treat appropriately without assistance from school personnel.

Section 2: Blood Glucose Monitoring at School

Type of Meter:_____

☐ Student can perform their own blood glucose checks. ☐ Student can Interpret results. ☐ Student needs supervision.

Time to be performed:
☐ Before breakfast ☐ Before PE/Activity Time ☐ Midmorning ☐ After PE/Activity ☐ Before lunch
☐ Mid-afternoon ☐ Dismissal ☐ As needed for signs/symptoms of low/high blood glucose

Insulin to Carbohydrate Ratio:_____
Carbohydrate counting: ☐ Student/family will calculate ☐ Needs assistance

Snacks (to be provided by parent/guardian/student):
☐ Midmorning ☐ Mid-afternoon ☐ Before PE/Activity ☐ After PE/Activity

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Section 3: Treatment of Blood Glucose Emergencies

Treatment of Low Blood Glucose - For blood glucose less than _____mg/dL:

1. Give _____ glucose tablets or_____ oz. juice or other non-diet drink or _____
2. Recheck BG in 15 minutes. If less than _____ mg/dL, repeat treatment and notify parent
3. When BG is greater than _____mg/dL, student may return to activities.

Treatment of Severe Hypoglycemia - If unconscious, unable to swallow or having seizures:

1. Delegate call to 9-1-1;
2. Assume low blood glucose is the problem and check blood glucose if possible;
3. Do not put anything in student's mouth if unable to swallow or having a seizure;
4. Give Glucagon _____ mg. subcutaneous injection per training; OR_____;
5. Place student on side (expect student to vomit if Glucagon given);
6. Notify contact person.

Treatment of High Blood Glucose - Blood glucose greater than _____mg/dL.

1. Follow orders regarding use of insulin at school;
2. Provide access to no-calorie fluids and toilet facilities;
3. Test ketones if ordered, if ketones are present follow orders;
4. If student is vomiting or feeling ill, call contact person;
5. If unable to reach contact person, call school district nurse or student's health provider.

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Section 3: Insulin Use at School

Type of Insulin: _____

☐ Vial ☐ Pen ☐ Pump ☐ No insulin to be given at school

☐ Student can perform their own injections. ☐ Student can determine correct amount of insulin. ☐ Student can draw correct amount of insulin.

Section 4: Insulin Dosing

☐ Sliding Scale Insulin ☐ See pump orders below

IF BLOOD GLUCOSE IS:	GIVE: (Type of insulin and amount)

Section 5: Students with Insulin Pumps

Type of pump: _____
Type of insulin in pump: _____
Type of infusion set: _____
Insulin/carbohydrate ratio: _____ Correction factor: _____
Basal Rate: _____
Insulin Sensitivity: _____

Student Pump Skills/Abilities:

☐ Bolus correct amount of carbohydrates consumed
☐ Calculate and administer corrective bolus
☐ Calculate and set basal profiles
☐ Calculate and set temporary basal rate
☐ Disconnect pump
☐ Reconnect pump at infusion set
☐ Prepare reservoir and tubing

The Parent/Guardian is responsible to provide all testing equipment and supplies needed for school. **If a student is unable to independently administer insulin dosing, parent/guardian must remain with the student on premises to carry out the child's Diabetes Treatment Orders. Logos does not have a medical professional on site; therefore we cannot administer insulin injections.** I consent to the release of the information pertaining to my child's diabetic care to the staff members who have custodial care and who may need to know this information to maintain my child's health and safety during the school day.

_____ _____

Parent/Guardian Signature Date