MEDICAL ORDER FOR MEDICATION AND TREATMENT IN SCHOOL

Student Name ________________________________ Date of Birth ________________________________
Diagnosis __________________________________ Grade ________________________________
School ________________________________________ Home Phone ____________________________
Health Care Provider ____________________________ Today’s Date ______________________________

Student Pump Skills

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

Medication & Treatment

<table>
<thead>
<tr>
<th>Medication &amp; Treatment</th>
<th>Dose</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood glucose testing with meter, lancets and strips</td>
<td>NA</td>
<td>Before lunch or any time student does not feel well</td>
</tr>
<tr>
<td>Urine ketone testing</td>
<td>NA</td>
<td>Any time blood glucose is &gt; 250 or when student is ill – follow emergency plan</td>
</tr>
<tr>
<td>Glucose tablets, Sweetarts®, LifeSavers®, juice or regular soda</td>
<td>• 2-4 glucose tablets&lt;br&gt;• 6-9 Sweetarts®&lt;br&gt;• 4-6 LifeSavers®&lt;br&gt;• 4-6 oz juice or soda</td>
<td>Any time blood glucose is &lt;70 – follow emergency plan</td>
</tr>
<tr>
<td>Glucagon – injectable</td>
<td>½ or 1 mg (circle appropriate dose) intramuscularly in leg, arm or buttock</td>
<td>Severe low blood glucose – the student cannot swallow, is unconscious or having a seizure – follow emergency plan</td>
</tr>
<tr>
<td>Treatment for nausea or vomiting</td>
<td>• Keep student turned on side&lt;br&gt;• Call 911&lt;br&gt;• Call parent and physician immediately</td>
<td>When student is nauseated or vomiting as a result of side effects of glucagons administration or high urine ketones – follow emergency plan</td>
</tr>
</tbody>
</table>

Specific Duration of Order ________________________________

Health Care Provider Signature ________________________________

Phone ________________________________

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.

Parent/Guardian Signature ________________________________ Home Phone ________________________________

Date ________________________________ Work Phone ________________________________

Other Phone (Cell or Pager) ________________________________