



Charleston County School District Medication/Procedure Doctor's Orders Insulin Ratio and Sliding Scale

Name of Student: _____ Date of Birth: _____

Diagnosis: Diabetes Mellitus - using ratio and sliding scale before lunch School: _____

Doctor's orders for medications or procedures at school or school related functions:

1. Check blood glucose before lunch or as needed for symptoms of hypoglycemia.
2. Blood glucose < 70, give 2-3 glucose tablets and recheck in 15 minutes. If unable to chew tabs, use glucose gel in cheek.
3. **UNCONSCIOUS hypoglycemia or seizure** – Give ____ mg Glucagon IM, turn to side and call EMS (911).
4. Blood glucose before lunch > _____, give _____ units of _____ insulin.
> _____, give _____ units of _____ insulin.
> _____, give _____ units of _____ insulin.
5. Insulin/carbohydrate ratio for meals is 1 unit of _____ insulin for every _____ grams carbohydrate. May be given after lunch at parent's request.
6. Check urine ketones if Blood glucose > 240. If moderate to large ketones, call parents and Pediatric Endocrinologist on call at 792-2123.
7. Comments/Special Instructions: _____

Self Monitoring and/or Medicating	
BLOOD GLUCOSE MONITORING (check box if you agree with the following statements)	INSULIN ADMINISTRATION (check box if you agree with the statements)
<input type="checkbox"/> This student has been instructed and is competent in using a blood glucose meter (understands indications, interpreting results, safety precautions and when to seek assistance.	<input type="checkbox"/> This student has been instructed and is competent in proper use of medication(s) noted above (understands indications, actions, side effects, when to take medication, when not to take medication and when to seek assistance.
<input type="checkbox"/> This student should be allowed to possess and self-monitor at school while in any area of the school or at any school sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school property and on school-sponsored field trips.	<input type="checkbox"/> This student should be allowed to possess and self-administer the above medications while in any area of the school or at any school sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school property, and on school-sponsored field trips.

The specific information provided on this form is part of the student's Individual Health Management Plan which I have reviewed and approved.

Legal prescriber (print name and title)

Signature of Legal prescriber

Office Phone: Pediatric Endocrinologist on call 792-2123 Fax: 843-876-1253 Date: _____

Signature of Parent/Legal Guardian

Date

I have read and understand the CCSD Medication/procedure policy and give permission for my child to receive the above medication/procedure as directed.