Charleston County School District
Medication/Procedure Doctor's Orders
Insulin Pump

Name of Student:_____ **Date of Birth:**_____
Diagnosis: Diabetes Mellitus on insulin pump **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. **Insulin/carbohydrate ratio is 1 unit for every _____grams of carbohydrate. May give bolus after lunch at parent's request.**
5. **Use high blood glucose bolus before lunch if >_____. Give 1 unit for every _____points > _____. (Target _____).**
6. **Check urine ketones if blood glucose > 240. If moderate to large ketones, call parents and Pediatric Endocrinologist on call at 792-2123. Give high blood glucose injection if before lunch as above.**
7. **Comments/Special Instructions:** _____
   _____

Self Monitoring and/or Medicating

BLOOD GLUCOSE MONITORING (check box if you you agree with the following statements)	INSULIN ADMINISTRATION (check box if you agree with the statements)
€ 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.	€ 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.
€ 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.	€ 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.

Charleston County SCHOOL DISTRICT excellence is our standard