

Insulin Injection & Medication Administration Addendum

Insulin to be given for: _____ (lunch, snack, etc)

Student:		DOB:		School:		Grade:	
Physician/Provider:				Phone:			
Diabetes Educator:				Phone:			

Insulin & Oral Medications:

<input type="checkbox"/> Oral Medication:	_____ mg by mouth	Time:	_____
	Dose: _____ units		
<input type="checkbox"/> NPH Insulin	SQ	Time:	_____ Rotate site

<input type="checkbox"/> Rapid Acting/Short Acting) Insulin Type:					
Blood Glucose Correction and Dosing using Rapid Acting Insulin					
Injection site: <input type="checkbox"/> Abdomen <input type="checkbox"/> Arm <input type="checkbox"/> Buttock <input type="checkbox"/> Thigh <i>Injections should be given subcutaneously & rotated</i>					
Lunchtime Correction: Give <input type="checkbox"/> Prior to lunch <input type="checkbox"/> Split ½ before lunch & ½ after lunch <input type="checkbox"/> Immediately after lunch <input type="checkbox"/> Other : _____					
<input type="checkbox"/> Sensitivity/Correction Factor: _____ unit insulin for every _____ mg/dl above target BG range starting at _____					
Blood Glucose Range:	mg/dl to	mg/dl	Administer	units	<input type="checkbox"/> Check ketones
			:		
Blood Glucose Range:	mg/dl to	mg/dl	Administer	units	<input type="checkbox"/> Check ketones
			:		
Blood Glucose Range:	mg/dl to	mg/dl	Administer	units	<input type="checkbox"/> Check ketones
			:		
Blood Glucose Range:	mg/dl to	mg/dl	Administer	units	<input type="checkbox"/> Check ketones
			:		
Blood Glucose Range:	mg/dl to	mg/dl	Administer	units	<input type="checkbox"/> Check ketones
			:		
<input type="checkbox"/> Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin per <i>Guidelines for Insulin Management</i> *					
When hyperglycemia occurs other than at lunchtime:					
<input type="checkbox"/> If it has been greater than 3 hours since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders if approved by the school nurse and parent is notified.					
<input type="checkbox"/> Notify School Nurse, Parents (who may come and give insulin) or School Nurse will contact Health Care Provider for One-time order as needed.					
Other: _____					
NOTE: Insulin Pen/Vial expires 28 days after it is opened and use is began					

Carbohydrates and Insulin Dosage: <input type="checkbox"/> Breakfast <input type="checkbox"/> Snack <input type="checkbox"/> Lunch <input type="checkbox"/> Other:					
Insulin to Carbohydrate Ratio: _____ unit(s) for every _____ grams of carbohydrate to be eaten					
<input type="checkbox"/> Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates					
Carb _____ gm	Administer _____ units		Carb _____ gm	Administer _____ units	
Carb _____ gm	Administer _____ units		Carb _____ gm	Administer _____ units	
Carb _____ gm	Administer _____ units		Carb _____ gm	Administer _____ units	
Carb _____ gm	Administer _____ units		Carb _____ gm	Administer _____ units	
Carb _____ gm	Administer _____ units		Carb _____ gm	Administer _____ units	
Carb _____ gm	Administer _____ units		Carb _____ gm	Administer _____ units	
Carb _____ gm	Administer _____ units		Carb _____ gm	Administer _____ units	
Comments: _____			<small>*Per Guidelines for Insulin Management (FEB 2013): Adjustments should not exceed three times per week for correcting BGs below target range, & not exceed two times per week for correcting BGs above the target range.</small>		

Parent Signature:		Date:
School Nurse Signature:		Date: