Insulin Injection & Medication Administration Addendum

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

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

Device: Pen: ☐____ Syringe and Vial: ☐____ In Pen: ☐________

☐ **Rapid Acting/Short Acting) Insulin Type:**					
Blood Glucose Correction and Dosing using Rapid Acting Insulin					
Injection site: ☐ Abdomen ☐ Arm ☐ Buttock ☐ Thigh	*Injections should be given subcutaneously & rotated*				
Lunchtime Correction: Give ☐ Prior to lunch ☐ Immediately after lunch ☐ Other :______					
☐ **Sensitivity/Correction Factor:**	_____ unit insulin for every _____mg/dl above target BG range starting at _____				
Blood Glucose Range:	< **mg/dl to**	**Treat mg/dl**	Administer	**0 units**	☐ Check ketones
Blood Glucose Range:	**70 mg/dl to**	**mg/dl**	Administer	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer	**units**	☐ Check ketones

☐ Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin *if noted on DMMP. If ongoing changes to the insulin dosing is a total of +/- 3 units per dose outside the current orders on file, new orders/DMMP are needed to reflect these changes. Per Standards of Care*

When hyperglycemia occurs other than at lunchtime:
☐ If it has been greater than **3 hours** since the last dose of insulin, **Contact School Nurse** and refer to **Standards of Care section: Hyperglycemia**.
Other: ______

NOTE: Insulin Pen/Vial expires 28 days after it is opened or pierced.

Carbohydrates and Insulin Dosage: ☐ **Breakfast** ☐ **Snack** ☐ **Lunch** ☐ **Other:**			
Insulin to Carbohydrate Ratio:	______**unit(s)** for every ______ **grams** of carbohydrate to be eaten		
☐ 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: ______		**Per Standards of Care): 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.*	

Parent Signature:		Date:
School Nurse Signature:		Date:
2nd RN review:		Date: