

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: _____

<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"/> 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	Treat mg/dl	Administer	0 units	<input type="checkbox"/> Check ketones
Blood Glucose Range:	70 mg/dl to	mg/dl	Administer	0 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
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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 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:					
<input type="checkbox"/> 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: <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 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.</small>		

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

