

**AMERICAN LEADERSHIP**  
**ACADEMY**  
**DIABETES MEDICAL ORDERS**

ALA CAMPUS: \_\_\_\_\_ SCHOOL YEAR: 20\_\_\_\_/20\_\_\_\_

STUDENT: \_\_\_\_\_ GRADE \_\_\_\_\_ TEACHER \_\_\_\_\_

**BLOOD GLUCOSE TARGET RANGE:** \_\_\_\_\_ mg/dl to \_\_\_\_\_ mg/dl

**Blood Glucose Testing:**

independent

needs assistance

\_\_\_\_ before AM snack

\_\_\_\_ before lunch

\_\_\_\_ before after-school sports

\_\_\_\_ when student feels low/high or ill

\_\_\_\_ other times \_\_\_\_\_

\_\_\_\_ if BG is less than \_\_\_\_\_ mg/dl or BG is greater than \_\_\_\_\_, call parent.

Comments: \_\_\_\_\_

For BG, lower than \_\_\_\_\_ or over \_\_\_\_\_ see Hypoglycemia Emergency Care Plan or DMMP

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**Urine Ketones Testing:**

\_\_\_\_ For BG greater than \_\_\_\_\_ mg/dl, do ketone testing.

If ketones are positive, contact parent and encourage sugar-free fluids.

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**Insulin Injection or Pump Bolus:**

independent

needs assistance

Type of Insulin \_\_\_\_\_

\_\_\_\_ Always call parent for dose.

\_\_\_\_ Bolus for meal, based on carbohydrate count.

\_\_\_\_ Correction or supplemental bolus for high BG

Comments: \_\_\_\_\_

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**For Students with Insulin Pump:**

Type of pump: \_\_\_\_\_

Does student need assistance with pump skills?

Yes

No

Comments: \_\_\_\_\_

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**Seizure, Unable to Swallow and/or Loss of Consciousness:**

\_\_\_\_ Glucose gel and **call 911.**

\_\_\_\_ Glucose gel, 1 mg of Glucagon IM or SQ and **call 911.**

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I give my permission for the school to contact my health care provider, \_\_\_\_\_, at  
(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (phone#) regarding the treatment of my child's diabetes.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_