Jefferson Parish Public School System
Physician's Orders For Students With Insulin Dependent Diabetes

Name of student: ________________________________ Date of Birth: __________
Diagnosis: ______________________________________________________________
Significant Health History: ________________________________________________
Special considerations specific to this student: ________________________________

Diet: __________________________ Snacks required at school? _____ Time: ______
Snacks may include: ______________________________________________________
Time(s) blood sugar testing at school: _______________________________________
Target blood sugar range: ________________________________________________
Treatment for blood sugar BELOW _________ mg/dl
____________________________________________________________________
____________________________________________________________________
Glucagon ordered at school? Yes _____ No _____ If yes, when: __________________

Is Glucagon necessary on the bus? Yes _____ No _____
Treatment for blood sugar ABOVE _________ mg/dl
____________________________________________________________________
____________________________________________________________________
Ketone testing: Blood Sugar > ________ / No testing needed ________
Treatment for positive ketones: ____________________________________________
____________________________________________________________________

Order date: ___________________________ Discontinue date: ________________
Please consider summer school and summer camp

____________________________________________________________________
____________________________________________________________________

PHYSICIAN'S SIGNATURE
Physician's Name: __________________________
Address: __________________________________
Phone: __________________________
Fax: __________________________