Diabetes Health Care Plan for Insulin Administration via Insulin Pump

School:_____

Start Date: _____ End Date: _____

Name:_____ Grade/ Homeroom: _____ Teacher:_____

Transportation: Bus Car Van Type 1 Type 2

Parent/ Guardian Contact: Call in order of preference

Name *Telephone Number* *Relationship*

1._____

2._____

3._____

Student Photo

Prescriber Name _____Phone_____Fax_____

Blood Glucose Monitoring: Meter Location _____ Student permitted to carry meter and check in classroom Yes No

BG= Blood Glucose **SG**= Sensor Glucose

Testing Time Before Breakfast/Lunch 1-2 hours after lunch Before/after snack Before/after exercise Before recess
Before riding bus/walking home **Always** check when student is feeling high, low and during illness
Other_____

Snacks: Please allow a ____gram snack at_____ ☐ before/after exercise, if needed

Snacks are provided by parent /guardian and located in _____

Treatment for Hypoglycemia/Low Blood Sugar

Signs of Low Blood Sugar
personality change, feels funny, irritability, inattentiveness, tingling sensations headache, hunger, clammy skin, dizziness, drowsiness, slurred speech, seeing double,
pale face, shallow fast breathing, fainting

If student is showing signs of hypoglycemia or if BG/SG is below _____mg/dl

☐ **Treat with _____ grams of quick-acting glucose:**

☐ ____oz juice or ____ glucose tablets or Glucose Gel or Other_____

Retest blood sugar every 15 minutes, repeat treatment until blood sugar level is above target _____mg/dl

☐ If no meal or snack within the hour give a 15 gram snack

☐ If student unconscious or having a seizure (severe hypoglycemia): Call 911 and then parents

Give Glucagon: Amount of Glucagon to be administered:_____(0.5 or 1mg) IM,SC **OR** Baqsimi 3 mg intranasally

☐ **Notify parent/guardian for blood sugar below _____mg/dl**

Treatment for Hyperglycemia /High Blood Sugar

If student showing signs of high blood sugar or if blood sugar is above _____mg/dl

☐ Allow free access to water and bathroom

☐ Check ketones for blood sugar over 250 mg/dl, Notify parent/guardian if ketones are **moderate to large**

☐ **Notify parent/guardian for blood sugar over** _____mg/dl

Student does not have to be sent home for trace/small urine ketones

☐ See insulin correction scale (next page)

☐ **Call 911 and parent/guardian for *hyperglycemia emergency*. Symptoms may include nausea &vomiting, heavy breathing, severe abdominal pain, chest pain, increased sleepiness or lethargy, or loss of consciousness.**

Document all blood sugars and treatment

Name: _____

Orders for Insulin Administered via Pump

Brand/Model of pump _____ Type of insulin in pump_____

Can student manage Insulin Pump Independently: ☐Yes ☐ No ☐Needs supervision (describe)_____

_____

Insulin to Carb Ratio: ___ units per _____grams Correction Scale: _____units per _____over _____mg/dl

Give lunch dose: ☐ before meals ☐ immediately after meals ☐ if BG/SG is less than 100mg/dl give after meals

☐Parents are authorized to adjust insulin dosage +/- by _____ units for the following reasons:

☐Increase/Decrease Carbohydrate ☐Increase/Decrease Activity ☐Parties ☐Other_____

Student may: ☐Use temporary rate ☐ Use extended bolus ☐Suspend pump for activity/lows

If student is not able to perform above features on own, staff will only be able to suspend pump for severe lows.

☐For BG/SG greater than 250 mg/dl that has not decreased in 2 hours after correction, consider pump failure or infusion site failure and contact parents. Check ketones.

☐For infusion set failure, contact parent/guardian: Can student change own infusion set ☐Yes ☐ No

☐ Student/parent insert new infusion set

☐ Administer insulin by pen or syringe using pump recommendation

☐For suspected pump failure suspend pump and contact parent/guardian

☐ Administer insulin by syringe or pen using pump recommendation

Activities/Skills	Independent	
Blood Glucose Monitoring	Yes	No
Carbohydrate Counting	Yes	No
Selection of snacks and meals	Yes	No
Treatment for mild hypoglycemia	Yes	No
Test urine/blood for ketones	Yes	No
Management of Insulin Pump	Yes	No
Management of CGM	Yes	No

Authorization for the Release of Information:

I hereby give permission for _____ (school) to exchange specific, confidential medical information with _____(Diabetes healthcare provider) on my child _____, to develop more effective ways of providing for the healthcare needs of my child at school.

Prescriber Signature_____Date_____

Parent Signature_____Date_____

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University Hospitals Rainbow Babies & Children's

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