

Diabetes Health Care Plan for Insulin Administration via Insulin Pump



School: _____

Start Date: _____ End Date: _____

Name: _____ Grade/ Homeroom: _____ Teacher: _____

| | | | | | | | | | | | | | |
|---|------------------|------------------|--------------|----------|-------|-------|----------|-------|-------|----------|-------|-------|---------------|
| Transportation: <input type="checkbox"/> Bus <input type="checkbox"/> Car <input type="checkbox"/> Van Parent/ Guardian Contact: Call in order of preference <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; text-align: center;">Name</td> <td style="width:33%; text-align: center;">Telephone Number</td> <td style="width:33%; text-align: center;">Relationship</td> </tr> <tr> <td>1. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>2. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>3. _____</td> <td>_____</td> <td>_____</td> </tr> </table> | Name | Telephone Number | Relationship | 1. _____ | _____ | _____ | 2. _____ | _____ | _____ | 3. _____ | _____ | _____ | Student Photo |
| Name | Telephone Number | Relationship | | | | | | | | | | | |
| 1. _____ | _____ | _____ | | | | | | | | | | | |
| 2. _____ | _____ | _____ | | | | | | | | | | | |
| 3. _____ | _____ | _____ | | | | | | | | | | | |
| Prescriber Name _____ Phone _____ Fax _____ | | | | | | | | | | | | | |
| Blood Glucose Monitoring: Meter Location _____ Student permitted to carry meter and check in classroom <input type="checkbox"/> Yes <input type="checkbox"/> No BG= Blood Glucose SG= Sensor Glucose Testing Time Before Breakfast/Lunch <input type="checkbox"/> 1-2 hours after lunch <input type="checkbox"/> Before/after snack <input type="checkbox"/> Before/after exercise <input type="checkbox"/> Before recess <input type="checkbox"/> <input type="checkbox"/> Before riding bus/walking home <input type="checkbox"/> Always check when student is feeling high, low and during illness <input type="checkbox"/> <input type="checkbox"/> Other _____ | | | | | | | | | | | | | |
| Snacks: Please allow a _____ gram snack at _____ <input type="checkbox"/> before/after exercise, if needed Snacks are provided by parent /guardian and located in _____ | | | | | | | | | | | | | |

Treatment for Hypoglycemia/Low Blood Sugar

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

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

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

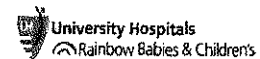
| Activities/Skills | Independent | |
|---------------------------------|-------------|----|
| Blood Glucose Monitoring | Yes | No |
| Carbohydrate Counting | Yes | No |
| Selection of snacks and meals | Yes | No |
| Treatment for mild hypoglycemia | Yes | No |
| Test urine/blood for ketones | Yes | 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 _____



Rev. 10/2019 Reviewed by
Drs. Carly Wilbur & Jamie Wood