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Diabetes Health Care Plan for Insulin Administration via Insulin Pump

School:_______________________________

Start Date: ______________________ End Date: ________________________

Name_________________________ Grade/ Homeroom ________________ Teacher_________________________

Student Photo

Parent/ Guardian Contact: Call in order of preference

Name *Telephone Number* *Relationship*

1.____

2.____

3. ____

Prescriber Name ___________________Phone_________________Fax___________________________

Blood Glucose Monitoring: Meter Location _________________________ Student permitted to carry meter ☐ Yes ☐ No

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

Snacks are provided by parent /guardian and located in _______________________________

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of low blood sugar or if blood sugar is below ________mg/dl

☐ **Treat with 10-15 grams of quick-acting glucose:**

☐ 4oz 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: Give Glucagon ☐ Yes ☐ No

☐ Amount of Glucagon to be administered: ________mg(s) IM, SC, and call 911 and parents

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

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

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 ______ mg/dl ☐ Notify parent/guardian if ketones are **moderate to large**

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

☐ 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 blood sugar 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 blood sugar greater than ____mg/dl that has not decreased in ____hours after correction, consider pump failure or infusion site failure and contact parents.

☐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

Continuous Glucose Monitor (CGM) **☐ Student not using CGM**

Name of CGM____

Alert for Low blood glucose _____mg/dl **Alert for High blood glucose _____mg/dl**

☐Verify all alarms with blood glucose finger stick before treatments

Do not disconnect CGM for sports of activities
If adhesive is peeling off reinforce with medical tape
If CGM falls off do not throw pieces away, place in a bag, contact and return to parents
Insulin injections should be at last 3 inches away from CGM device
Do not give Tylenol while using the CGM
Other instructions from MD regarding using CGM for insulin dosing **☐Yes** **☐ No**

____

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___________________

Reviewed by Dr. Carly Wilbur April 2019

Parent Signature_______________________________________Date___________________