Diabetes Health Care Plan for Insulin Administration via Insulin Pump

School: ____________________________

Start Date: ____________________________ End Date: ____________________________

Name ____________________________ Grade/ Homeroom ________________ Teacher ____________________________

Parent/ Guardian Contact: Call in order of preference

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
<th>Relationship</th>
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<tbody>
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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__________________________

Blood Glucose Monitoring

Snacks
☐ Please allow a ______ gram snack at_______ ☐ before/after exercise

Snacks are provided by parent/guardian and located in _________________________________

Prescriber Name ____________________________ Phone________________ Fax___________________________

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

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 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: ☐ 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 least 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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
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<tbody>
<tr>
<td>Blood Glucose Monitoring</td>
<td>Yes</td>
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<tr>
<td>Carbohydrate Counting</td>
<td>Yes</td>
</tr>
<tr>
<td>Selection of snacks and meals</td>
<td>Yes</td>
</tr>
<tr>
<td>Treatment for mild hypoglycemia</td>
<td>Yes</td>
</tr>
<tr>
<td>Test urine/blood for ketones</td>
<td>Yes</td>
</tr>
<tr>
<td>Management of Insulin Pump</td>
<td>Yes</td>
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<tr>
<td>Management of CGM</td>
<td>Yes</td>
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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__________________