

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 <input type="checkbox"/> Yes <input type="checkbox"/> No
Testing Time <input type="checkbox"/> 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"/> Before riding bus/walking home <input type="checkbox"/> Always check when student is feeling high, low and during illness			
<input type="checkbox"/> Other _____			
Snacks			
<input type="checkbox"/> Please allow a _____ gram snack at _____ <input type="checkbox"/> 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

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

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 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 or 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	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 _____

