

# 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> Prescriber Name _____ Phone _____ Fax _____	Name	Telephone Number	Relationship	1. _____	_____	_____	2. _____	_____	_____	3. _____	_____	_____	Student Photo
Name	Telephone Number	Relationship											
1. _____	_____	_____											
2. _____	_____	_____											
3. _____	_____	_____											

**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 \_\_\_\_\_

**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 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**

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

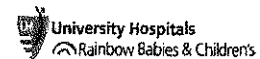
Activities/Skills	Independent	
Blood Glucose Monitoring	Yes	No
Carbohydrate Counting	Yes	No
Selection of snacks and meals	Yes	No
Treatment for mild hypoglycemia	Yes	No
Test urine/blood for ketones	Yes	No
Management of Insulin Pump	Yes	No
Management of CGM	Yes	No

**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