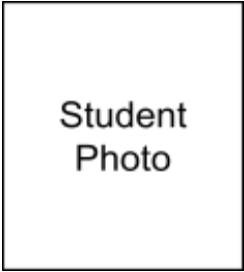




Fairbanks North Star Borough School District
Diabetes Pump Care Plan



LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

EQUIPMENT (provided by parent/guardian to school nurse)

Pump Model _____ Insulin _____ Basal Rate _____ Mode _____
 CGM Type _____ Backup Glucometer Glucometer strips Lancets
 Snacks (fast acting carbs, protein) Ketone test strips Emergency meds Other: _____

SCHEDULED CARE

Step 1. Blood Glucose Correction (BGC) Insulin Dose

Check Current Blood Glucose and give BGC Dose May use CGM for BGC dosing
 Before Breakfast Before Lunch Per Pump Other: _____

Insulin dosing per pump recommendations. Using the following parameters and formula:
 Verify pump settings for:
 Target Blood Glucose: _____ Insulin Sensitivity Factor: _____

$$\frac{\text{(Current BG - Target BG)}}{\text{Insulin Sensitivity Factor}} = \text{Units of Insulin}$$

DO NOT GIVE BGC MORE THAN ONCE EVERY THREE HOURS

Step 2. Carbohydrate Coverage Insulin Dose

Calculate Carbohydrate Intake Before consuming carbs After consuming carbs
 And give Carbohydrate Coverage Insulin Dose for:
 All carb intake Breakfast Lunch Snacks Per Pump Other: _____

Using the built-in carb coverage ratio input. Using the following parameters and formula:
 Verify pump Insulin/Carb ratios:
 Time/Meal: _____ Ratio: _____ : _____
 Time/Meal: _____ Ratio: _____ : _____
 Time/Meal: _____ Ratio: _____ : _____
 Time/Meal: _____ Ratio: _____ : _____
 Time/Meal: _____ Ratio: _____ : _____

$$\frac{\text{Total grams of Carbohydrates to be eaten}}{\text{Grams of CHO per 1 unit of insulin}} = \text{Units of Insulin}$$

If BG <70 before a meal, follow Algorithms for Blood Glucose Results.

Step 3. BGC + Carbohydrate Coverage = Insulin Dose

Input the Blood Glucose and Carbohydrates to be consumed into the pump

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Fairbanks North Star Borough School District Diabetes Pump Care Plan

PRN CARE

Check Blood Glucose using CGM

- Before Exercise/PE/Gym/Recess After Exercise/PE/Gym/Recess Before leaving school

Check Blood Glucose using Glucometer

- For signs and symptoms of hyper/hypoglycemia To confirm hypo- or hyperglycemia
 CGM indicates rapid change prior to BGC dose To calibrate CGM Other: _____

Check Ketones

- For BG >250 mg/dL, repeat in 2 hours. If still >250 mg/dL, check urine ketones and refer to Algorithm.
 For signs of DKA ("three P's" - polyuria, polydipsia, polyphagia, abdominal pain, vomiting)

Exercise/PE/Gym/Recess

A quick-acting source of glucose such as a glucose tab or sugar-containing juice should be available at the site of the physical activity.

- Student should eat _____ grams of CHO Before Q30min Q1H After activity
 If pre-exercise blood glucose is **less than 70 mg/dL**, student can participate in physical activity once blood glucose is corrected and **above 120 mg/dL**.
 If pre-exercise blood glucose is **less than 120 mg/dL**, student can participate in physical activity once they **consume 15 grams** CHO with protein.
 If student is to exercise right after lunch, student should subtract _____ gm from their Carbohydrate coverage.
 Turn on Activity Mode
 Decrease Temp Basal Rate by _____ % _____ units for _____ min Duration of exercise.
 Activate Temp Target BG for _____ min before _____ min after Duration of exercise.
 May disconnect from the pump for exercise, but no longer than 2 hours.
 Student should monitor blood glucose hourly.

Other Care

- Yes No Parents/Guardians are allowed to adjust insulin doses 20% higher or lower.
 Yes No Pump settings should not be changed, unless directed by the ordering provider.
 Yes No Suspend pump when BG <70 mg/dL and reactivate at 85 mg/dL

If infusion set comes out or fails: Change set at school Follow BCG every three (3) hours

OTHER MEDICATION

<input type="checkbox"/> Tresiba (Insulin glargine) _____ units SQ DAILY to be witnessed or performed by nurse or trained staff.
<input type="checkbox"/> Fast-acting insulin _____ if pump set comes out and follow BCG and Carb Coverage orders.
<input type="checkbox"/> Baqsimi 3 mg Intranasal PRN for hypoglycemia <70 and unable to swallow. Recheck BG in 15 min and if <70, give a second dose and call 911.
<input type="checkbox"/> Glucagon _____ mg IM or SQ PRN for hypoglycemia <70 and unable to swallow. Recheck BG in 15 min and if <70, call 911.

NOTES

MEDICAL PROVIDER SIGNATURE	DATE
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Medical Provider Assessment of Student's Diabetes Management Skills				
Skill	Independent	With Supervision*	Cannot Do	Notes
Check Blood Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Count carbohydrates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calculate insulin dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insulin administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Troubleshoot CGM alarms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Troubleshoot Pump alarms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Set Temp Basal/Temp Target	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Change infusion set	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>*The nurse or other trained staff are expected to observe for accuracy and completion of skills "with supervision."</i>				
MEDICAL PROVIDER NAME/TITLE			PHONE	
MEDICAL PROVIDER SIGNATURE			DATE	

PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION		
<p>I request that the medication(s) and diabetes care outlined on this plan be given to my child. I will provide needed medications or supplies for care in school.</p> <p>Employees and agents of the Fairbanks North Star Borough School District ("FNSBSD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless FNSBSD from any liability for the risks or results of the care provided, the self-management or storage of diabetes medications and blood glucose products, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify FNSBSD immediately if the medications or protocols change. I understand and authorize that, in the absence of Health Services personnel, other designated and trained Fairbanks North Star Borough School District ("FNSBSD") personnel may provide and administer care. I give permission for the exchange or release of health information between the medical provider listed above and FNSBSD as part of the provision of my child's care. I agree for the health office staff to share health information with FNSBSD staff on a need-to-know basis for my child's safety and to foster academic success.</p> <p>I understand that ANY remaining diabetes care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the FNSBSD school year calendar.</p> <p>THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL</p>		
PARENT/GUARDIAN NAME	RELATIONSHIP TO STUDENT	PHONE NUMBER
PARENT/GUARDIAN SIGNATURE		DATE

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LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
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AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

Student Agreement: I agree to safely dispose of any sharps either by keeping them in my kit to take home or by placing them in the designated sharps container provided at school. If specified in my Individualized Healthcare Plan, I will notify the health office if my blood sugar falls below _____ mg/dl or rises above _____ mg/dl. I understand that my diabetes supplies are for my use only and will not allow anyone else to use them. I understand that being allowed to manage my diabetes independently at school is a privilege, and I agree to follow the expectations outlined in this agreement.

Parent/Guardian Agreement: I agree that my child is capable of self-managing his/her diabetes and can recognize when to seek help from a staff member. I authorize my child to carry and self-administer diabetes medications and management supplies, I will provide backup supplies to the health office in case of emergencies. I understand that this agreement remains in effect for the current school year unless it is revoked by my child's physician or if my child fails to meet the safety guidelines outlined above.

PARENT/GUARDIAN SIGNATURE	
STUDENT SIGNATURE	DATE

NURSE PLAN REVIEW

I have reviewed the Diabetes Pump Care Plan for accuracy and ensure that all required fields and signatures are completed before providing care to a student. I approve of the agreement arranged between the healthcare practitioner, parent, health office, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME	
NURSE SIGNATURE	DATE

ADAPTED AND REPRINTED WITH PERMISSION FROM THE ANCHORAGE SCHOOL DISTRICT

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