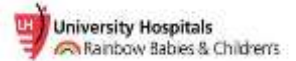
Diabetes Health Care Plan for Insulin Administration via Insulin Pump



School:_______________________________

Start Date: _____________ End Date: ______________ Grade/Homeroom: _______
Name:_________________________ DOB: __________ Teacher:_________________________

Transportation: ☐ Bus ☐ Car ☐ Van ☐ Type 1 ☐ Type 2

Parent/ Guardian Contact: Call in order of preference

Name *Telephone Number* *Relationship*

1.____
2.____
3. ____

Student Photo

Prescriber Name ______________________Phone: 216-844-3661 Fax: 216-844-8900

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_____ ☐____gram snack before/after exercise, if needed

Snacks are provided by parent /guardian and located in __________________

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 student unconscious or having a seizure (severe hypoglycemia): Administer glucagon (see below), and call 911 and then parents

☒ Give Glucagon: ☐ Baqsimi 3mg intranasally

☐ Glucagon/Gvoke: dose ______ mg SQ

☒ **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 _250_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; give correction as pump recommends (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

Rev. 05/2023 Reviewed by Dr. Jamie Wood

Name: ________________________ DOB: ___________________

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)__________

____

Settings in pump**:**

Insulin to Carb Ratio: 1 units per _____grams   Correction Scale: 1 units per ____over _____mg/dl

Give lunch dose: ☐ before meals ☐ immediately after meals ☐ if BG/SG is less than 100mg/dl give after meals

☒ Follow pump dosing as pump recommends (pump dose may be different than manually calculated dose due to IOB)

☐ 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 ☐ Use exercise/activity mode

If student is not able to perform above features on own and school staff is not trained on these features, 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	Needs supervision
Carbohydrate Counting	Yes	No	Needs supervision
Selection of snacks and meals	Yes	No	Needs supervision
Treatment for mild hypoglycemia	Yes	No	Needs supervision
Test urine/blood for ketones	Yes	No	Needs supervision
Management of Insulin Pump	Yes	No	Needs supervision
Management of CGM	Yes	No	Needs supervision

Authorization for the Release of Information:

I hereby give permission for _________________________ (school) to exchange specific, confidential medical information with RBC Pediatric Endocrinology (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___________________

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