

# Diabetes Health Care Plan for Insulin Administration via Insulin Pump



School: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Name: \_\_\_\_\_ Grade/ Homeroom: \_\_\_\_\_ 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 \_\_\_\_\_ Fax \_\_\_\_\_

**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	
	Yes	No
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 \_\_\_\_\_



**Reviewed by**  
**Drs. Carly Wilbur & Jamie Wood**