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

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
<th>Relationship</th>
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<tbody>
<tr>
<td>1. ________________</td>
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<td>2. ________________</td>
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<td>3. ________________</td>
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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 ________________

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

Rev. 10/2019 Reviewed by Drs. Carly Wilbur & Jamie Wood

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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

<table>
<thead>
<tr>
<th>Activities/Skills</th>
<th>Independent</th>
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<tbody>
<tr>
<td>Blood Glucose Monitoring</td>
<td>Yes</td>
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<tr>
<td>Carbohydrate Counting</td>
<td>Yes</td>
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<tr>
<td>Selection of snacks and meals</td>
<td>Yes</td>
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<tr>
<td>Treatment for mild hypoglycemia</td>
<td>Yes</td>
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<tr>
<td>Test urine/blood for ketones</td>
<td>Yes</td>
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<tr>
<td>Management of Insulin Pump</td>
<td>Yes</td>
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<tr>
<td>Management of CGM</td>
<td>Yes</td>
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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

SCHOOL FAX NUMBERS
Middle School: 440.449.1413  Lander: 440.995.7355  CEVEC: 440.646.1117