

Diabetes Management Plan – Insulin Pump

Student:	Birthdate:
Teacher/Grade:	Transportation <input type="checkbox"/> Bus # <input type="checkbox"/> Car rider

Blood Glucose (BG)-Monitoring : Before meal Before Exercise Before snack Before bus/dismissal
 If symptoms of low or high blood glucose Other _____

- Target range for blood glucose is _____ mg/dl. To _____ mg/dl
- Notify parent if blood glucose is below _____ mg/dl and/or higher than _____ mg/dl
- Type of meter _____ Meter to be stored in: Medication Room Classroom or Student’s book bag

Pump Info: Type of pump: _____

Note: *Pump settings are established by the student’s healthcare provider and should not be changed by school staff.*

- *Extra pump supplies furnished by parent/guardian (infusion sets, reservoirs, batteries, back-up insulin).*
- *School staff are not responsible for changing infusion site.*
- *Contact parent/guardian with any concerns about pump such as redness or soreness at site, pump failure... etc.*

Hypoglycemia (Low blood glucose): Student should be sent to office accompanied by an adult if symptomatic or if blood glucose is less than 80mg/dL.

- This student’s most common complaint(s) when blood glucose is low or dropping is: _____
- Test blood glucose if complains – if blood glucose meter is not available, treat symptoms.
- For blood glucose less than _____ mg/dL: Treat with 15 gram carbohydrate snack (juice, glucose tab, etc...) and recheck and retreat if necessary every 10-15minutes until above _____ mg/dL. Then treat with protein snack or lunch and notify parent.
- Carbohydrates that were used to bring blood glucose up to within target range should NOT be covered with insulin.
- **If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give: Glucagon _____mg(s) IM or SQ and call 911, position student on side because may vomit, then notify parent /guardian. When regains consciousness follow with fast sugar. Disconnect pump and send it with EMS.**

Hyperglycemia (High blood glucose):

- This student’s most common complaint(s) when blood glucose is high is: _____
- If elevated blood glucose, encourage water or sugar-free fluids. Allow unrestricted bathroom privileges.
- **Check urine ketones if blood glucose is over _____ or with symptoms of nausea/vomiting.** If ketostix is not available, continue with treatment steps listed below. **Recheck blood glucose in:** 1 hour 2 hours.
- If student has moderate to large ketones and/or symptoms of nausea and vomiting call parent/guardian to pick up in order to be treated and monitored more closely and encourage to call the doctor. Student should not exercise.
- For blood glucose greater than _____ mg/dL AND at least 2 hours since last insulin dose, give correction dose of insulin (see correction scale on page 2).
- No exercise if blood glucose is higher than _____ mg/dL or if urine/blood ketones are moderate to large.
- **Blood glucose above _____ mg/dl with ketones that has not decreased within _____ hours after correction, may indicate a malfunctioning pump. Student may require insulin via injection and /or new infusion site/set. Notify parent/guardian**

(Continued on back of sheet)

Student Name: _____ Date of Birth: _____

Insulin Therapy: Meals

- Bolus for carbohydrates should occur immediately: Before meal After meal
- Correction dose: should be at least 2 hours since last insulin dose.

Breakfast:	Carbohydrate limit for meal: _____ grams <input type="checkbox"/> no limit
	Give _____ units of insulin per _____ grams of carbohydrates
Lunch:	Carbohydrate limit for meal: _____ grams <input type="checkbox"/> no limit
	Give _____ units of insulin per _____ grams of carbohydrates
Snack:	Student to have scheduled snack: <input type="checkbox"/> yes <input type="checkbox"/> no If yes, when:
	<input type="checkbox"/> If snack greater than _____ grams of carbohydrates cover with insulin
	Give _____ units of insulin per _____ grams of carbohydrates
	<input type="checkbox"/> No insulin coverage for snacks.

Insulin administration: Correction scale: Blood glucose corrections and insulin dosage for pump malfunction
(Can be used every 2 hrs. If needed)

- Type of insulin: _____
- Back-up insulin to be administered via: Syringe Yes No Insulin Pen Yes No

Blood Glucose Range _____ mg/dL Administer _____ units
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Parent/Guardian authorized to increase or decrease correction scale within the following range: +/-2 units of insulin.
 Yes No

Student's Ability to Self manage diabetes

Totally independent in all aspects of care: Yes No If you answered yes, skip to signatures

STUDENT PUMP SKILLS ASSESSMENT

Skill	Yes	No	Skill	Yes	No
Needs staff observation testing blood glucose			Troubleshoots all alarms and malfunctions		
Needs assistance testing blood glucose			Administers insulin by pen/injection if needed independently		
Needs assistance counting carbohydrates			Student/parent inserts new infusion set		
Manages pump boluses independently			Recognizes signs/symptoms of site infection		
Tests and interprets urine ketones independently			Disconnects pump if needed		
Monitors own snacks and meals			Reconnects pump if needed		

Signatures

1. Physician Authorization for Medication Administration and Specialized Health Care procedures:

Physician's signature: _____ Date: _____

Physician's Address or stamp:

Office telephone: _____

Fax # _____

Student Contract for Self-Administered Medication:

- I will be responsible for my own diabetic supplies at school. Where are the diabetic supplies kept during the school day? _____
- I agree to use my diabetic supplies/medication in a responsible manner, in accordance with my doctor's orders.
- I will notify the school nurse or main office if I am having difficulty with my diabetes.
- I will not allow any other person to use my diabetic supplies/medication.

Student signature _____ Date: _____

Nurse signature _____ Date: _____