Kimberly School District #414

141 Center Street West Kimberly, Idaho 83341 Phone: 208-423-4170 Fax: 208-423-6155

HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN

STUDENT WITH DIABETES USING INSULIN **PUMP**

EFFECTIVE DATE:	End Date:
STUDENT'S NAME:	Date of Birth:

DIABETES HEALTHCARE PROVIDER INFORMATION Name:
Phone #: Fax #:

SCHOOL: School Nurse Phone: 208-423-4170 EXT 3331

Monitor Blood Glucose:

☐ Check as needed if student has symptoms of high or low blood glucose or does not feel well
☐ Before lunch ☐ Other: ______________________________
☐ Before PE ☐ Other: ______________________________
☐ Before leaving school ***Where to check:*** ☐ Anywhere ☐ Classroom ☐ Office

Insulin Pump Information: ☐*Humalog or NovoLog or Apidra by pump* ☐Other: ________________________

Target Range: _______ - _______ mg/dl Notify parents when BG is <_______or >________.

Carbohydrate Coverage:

Give 1 unit of insulin per:
gm carbohydrate at breakfast
gm carbohydrate at AM snack
gm carbohydrate at lunch
gm carbohydrate at PM snack

Bolus should occur: before eating, or
other:_____________________

Correction Bolus for Hyperglycemia:
All blood glucose results should be entered into pump to determine need for bolus correction.
Times given: Before AM snack Before lunch
Before PM snack
Use pump suggested correction

Give 1 unit of insulin for every ______ mg/dl, with a target blood glucose of _____ mg/dl.

Formula used to calculate correction:
BG ______ minus (-) target BG_____ = ____
Then divide (÷) by correction factor _____ = _____.

☐***Check Ketones*** if nauseated, vomiting or has abdominal pain, or if blood glucose > 300 twice when tested 2-3 hours apart.

☐ Use correction formula <u>via syringe/pen.</u>

☐ Use correction formula <u>via syringe/pen</u>, and give an additional _____ units of insulin for moderate ketones, and _______ units for large ketones.

*** Repeat ketone check in 2 hours, and repeat additional insulin if moderate or large ketones are still present.

* Basal insulin will be running continuously during school. Notes: ______________________________________
____

* If infusion set comes out or needs to be changed: ☐Insulin via syringe every 3 hours ☐Change set at school

Moderate Exercise (lasting 30 minutes or more) and Sports with Pump:
Temporary Basal Decrease: ☐No ☐ Yes _______% for _______ minutes OR ☐ for duration of exercise)
Student should monitor blood glucose hourly or when there are signs/symptoms of low/high blood glucose.

Hypoglycemia:
Student should not be sent to office unaccompanied if symptomatic or BS < ______ mg/dl.
Check blood glucose - if blood glucose meters not available, treat symptoms.
Blood glucose between ___ - ____ mg/dl and/or symptomatic: Treat with _____ gm carbohydrate (juice, glucose tabs, etc).

- **Mild symptoms:** Treat with _____ gms carbs. (juice, glucose tabs, etc) until above ______ mg/dl, then snack or lunch.
- **Moderate symptoms** if unable to drink juice: Administer glucose gel/tube frosting. Retreat until above ______mg/dl, then snack or lunch.
- **Severe symptoms** which may include seizures, unconscious, unable or unwilling to take gel or juice:
  ☐ Administer Glucagon____ mg(s) IM if trained staff available and call 911.
  ☐ Disconnect pump.

Do not bolus for carbohydrates given to treat low blood glucose until blood glucose is > 70 mg/dl.

HCP Assessment of Student's Diabetes Management Skills:

Skill	*Independent*	*Needs supervision*	*Cannot do*
Check blood glucose			
Count carbohydrates			
Deliver insulin bolus			
Change infusion set			
Calculate dose & inject			
Trouble shoot alarms, malfunctions			

☐Student may advance in independence through school year if school and parent agrees.

Parent/Guardian Authority:

- To adjust insulin dose:
  ☐ Yes ☐ No
- To change frequency of BG monitoring:
  ☐Yes ☐ No

Notes:

HEALTHCARE PROVIDER SIGNATURE:	Date:
PARENT/ GUARDIAN SIGNATURE:	Date:

UPDATES TO THE
HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN
STUDENT WITH DIABETES USING INSULIN **PUMP**

STUDENT'S NAME:	Date of Birth:
DIABETES HEALTHCARE PROVIDER INFORMATION Name:	
Phone #: Fax #:	Email:
SCHOOL:	School Fax:

Effective Date:	**Update:**
Healthcare Provider signature:	
Parent/Guardian signature:	
Healthcare Provider signature:	
Parent/Guardian signature:	
Healthcare Provider signature:	
Parent/Guardian signature:	
Healthcare Provider signature:	
Parent/Guardian signature:	
Healthcare Provider signature:	
Parent/Guardian signature:	