

**DIABETES MEDICAL MANAGEMENT PLAN SUPPLEMENT FOR STUDENTS WEARING INSULIN PUMP**

School Year \_\_\_\_\_ - \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Pump Brand/Model: \_\_\_\_\_

Pump Resource Person: \_\_\_\_\_ Phone/Beeper: \_\_\_\_\_ (See basic diabetes plan for parent phone #)

Child Lock On?  YES  NO How long has student worn an insulin pump? \_\_\_\_\_

Blood Glucose Target Range \_\_\_\_\_ Pump Insulin:  Humalog  Novolog  Regular

Insulin: Carbohydrate Ratios: \_\_\_\_\_

(Student to receive carbohydrate bolus *immediately before* / \_\_\_\_\_ *minutes before eating*)

Lunch/Snack Boluses Pre-programmed?  YES  NO Times: \_\_\_\_\_

Insulin Correction Formula for Blood Glucose Over Target: \_\_\_\_\_

Extra Pump supplies furnished by parent/guardian:  infusion sets  reservoirs  batteries  dressings/tape  insulin  syringe/pen

| STUDENT PUMP SKILLS                               | NEEDS HELP?  | IF YES, TO BE ASSISTED BY AND COMMENTS |
|---|--|--|
| 1. Independently count carbohydrates              | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 2. Give correct bolus for carbohydrate consumed   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 3. Calculate and administer correction bolus      | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 4. Recognize signs/symptoms of site infection     | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 5. Calculate and set a temporary basal rate       | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 6. Disconnect pump if needed                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 7. Reconnect pump at infusion set                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 8. Prepare reservoir and tubing                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 9. Insert new infusion set                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10. Give injection with syringe or pen, if needed | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 11. Troubleshoot alarms and malfunctions          | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 12. Pre-program basal profiles if needed          | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |

**MANAGEMENT OF HIGH BLOOD GLUCOSE** *Follow instructions in basic diabetes medical management plan, but in addition:*

If blood glucose over target range \_\_\_\_\_ hours after last bolus or carbohydrate intake, student should receive a correction bolus of insulin using formula; Blood glucose - \_\_\_\_\_ ÷ \_\_\_\_\_ = \_\_\_\_\_ units insulin

If blood glucose over 250, check urine ketones

- If no ketones**, give bolus by pump and recheck in 2 hours
- If ketones present or** \_\_\_\_\_, give correction bolus as an injection immediately and contact parent/health care provider

If two consecutive blood glucose readings over 250 (2 hours or more after first bolus given)

- Check urine ketones
- Give correction bolus as an injection
- Change infusion set
- Call parent

**MANAGEMENT OF LOW BLOOD GLUCOSE** *Follow instructions in Basic Diabetes Care Plan, but in addition:*

**If low blood glucose recurs without explanation**, notify parent/diabetes provider for potential instructions to suspend pump.

**If seizure or unresponsiveness occurs:**

- Call 911 (or designate another individual to do so).
- Treat with Glucagon (See basic Diabetes Medical Management Plan)
- Stop insulin pump by:
  - Placing in "suspend" or stop mode (See attached copy of manufacturer's instructions)
  - Disconnecting at pigtail or clip (Send pump with EMS to hospital)
  - Leakage of insulin
- Notify parent
- If pump was removed, send with EMS to hospital

**ADDITIONAL TIMES TO CONTACT PARENT**

- |   |  |
|---|--|
| <input type="checkbox"/> Soreness or redness at infusion site             | <input type="checkbox"/> Insulin injection given |
| <input type="checkbox"/> Detachment of dressing/infusion set out of place | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> Leakage of insulin                               |  |

Effective Date (s) of Pump plan: \_\_\_\_\_

Parents Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Diabetes Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_