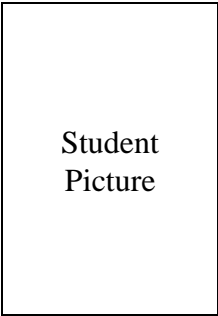


# Diabetes with Pump Care Plan

# Durango School District 9R

Student Name:	Birth Date:
Teacher:	Grade:
Parent/Guardian:	Cell Phone:
	Home Phone:
Other Contact:	Phone:
District Nurse:	Phone:
Physician:	Phone:
Diabetes Educator:	Phone:
Hospital of Choice:	504 Plan on File: <input type="checkbox"/> Yes <input type="checkbox"/> No



Student has:  Type 1 Diabetes  Type 2 Diabetes      Date of Diagnosis: \_\_\_\_\_  
 Target Blood Glucose Range \_\_\_\_\_ To \_\_\_\_\_  
 Call Parent of Blood Glucose values are below \_\_\_\_\_ or above \_\_\_\_\_

Required blood glucose checking at school	Times to check blood glucose
<input type="checkbox"/> Trained personnel must perform blood glucose checks <input type="checkbox"/> Trained personnel must supervise blood glucose checks <input type="checkbox"/> Student can perform checks independently <input type="checkbox"/> Student can carry supplies and check where needed	<input type="checkbox"/> Before meals <input type="checkbox"/> After meals <input type="checkbox"/> Before snack <input type="checkbox"/> Before P.E. <input type="checkbox"/> After P.E. <input type="checkbox"/> Before getting on bus/going home <input type="checkbox"/> As needed for signs/symptoms of low/high blood glucose <input type="checkbox"/> Other list _____
<b>Schedule</b> Lunch time _____ Scheduled P.E. time _____ Recess time _____ Snack time(s) _____ a.m., _____ p.m. Location where snacks are kept _____ Location where snacks are eaten _____	

Medications to be given		
<input type="checkbox"/> Oral diabetes medication(s), Type _____	Dose _____	Times to be given _____
<input type="checkbox"/> Insulin, Type _____	Times to be given _____	

Calculating a Meal or Snack Insulin Dose	
Times to Bolus: <input type="checkbox"/> Before meal/snack <input type="checkbox"/> After meal/snack <input type="checkbox"/> ½ bolus before meal/snack & ½ after <input type="checkbox"/> Other: _____	
1. Check blood glucose level before/after the meal/snack 2. Enter the blood glucose value into the pump by <input type="checkbox"/> student <input type="checkbox"/> student w/supervision <input type="checkbox"/> delegated staff 3. Count the grams of carbohydrates in the food eaten/to be eaten by <input type="checkbox"/> student <input type="checkbox"/> student w/supervision <input type="checkbox"/> delegated staff 4. Enter the grams of carbohydrates into the pump by <input type="checkbox"/> student <input type="checkbox"/> student w/supervision <input type="checkbox"/> delegated staff 5. The <b>pump will calculate the prescribed amount of insulin</b>	6. Deliver the bolus dose by pressing the button(s) on the pump by <input type="checkbox"/> student <input type="checkbox"/> student w/supervision <input type="checkbox"/> delegated staff 7. If bolus given prior to meal, do not administer more than 10 minutes before eating 8. If blood glucose is less than _____ mg/dl, wait to give meal bolus until after meal 9. If blood glucose is greater than _____ mg/dl, deliver a correction to bolus prior to eating

<b>The settings on the pump are established by the student's healthcare provider and should not be changed by school personnel.</b> <input type="checkbox"/> Parent/guardian authorized to increase or decrease insulin to carbohydrate count within the following: 1 unit per +/- 5 grams of carbohydrates
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Field Trips and Special Events
➤ Staff must notify parent and school nurse in advance so proper training and preparations can be accomplished. ➤ Adult staff must be trained and responsible for student's needs on field trip/event. ➤ Extra snacks, blood glucose meter, copy of health plan, emergency glucose, and emergency supplies must accompany student. ➤ Adults accompanying student on the field trip/event will be notified of student's health accommodations on a need-to-know basis.

Parent Initials \_\_\_\_\_

Student Name \_\_\_\_\_

## ↓ Low Blood Sugar – Below \_\_\_\_\_ mg/dl

### Causes:

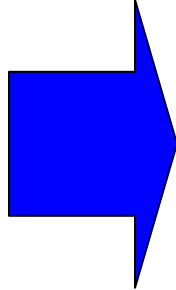
- Too much insulin
- Too much exercise
- Too few carbohydrates consumed
- High excitement

### Mild Low Blood Glucose

#### If you See This:

#### Student is Alert

- Headache
- Sweating, pale
- Shakiness, dizziness
- Tired, falling asleep
- Inability to concentrate
- Poor coordination
- Irritable
- Eyes dilated, glassy



#### Do This:

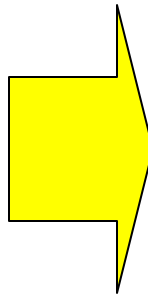
- Check blood glucose
- If less than \_\_\_\_\_ mg/dl, give 15-20gr. carbohydrates:
  - 4-6oz. fruit juice
  - 4-6oz. sugared soda
  - 8-12 Sweetarts® or Smarties® candy
  - 3 peppermints
- DO NOT BOLUS INSULIN FOR THESE CARBS!**
- After 15 minutes, check blood glucose again
- Repeat if necessary until blood glucose is > \_\_\_\_\_ mg/dl
- Follow with a protein/carbohydrate snack (15-20gr. carbs), peanut butter & crackers or cheese & crackers
- Remain with student until recovered
- Notify parent/guardian

### Moderate Low Blood Glucose

#### If You See This:

#### Student is Not Alert

- Severe confusion
- Disorientation
- Not able or unwilling to swallow
- May be combative
- Slurred speech



#### Do This:

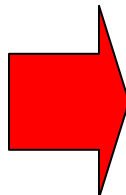
- Check blood glucose
- Keeping head elevated, rub one of the following between cheek and gum:
  - 1 tube Cake Mate®
  - 1 tube instant glucose gel
- After 15 minutes check blood glucose again
- Re-treat if necessary, until blood glucose is > \_\_\_\_\_ mg/dl
- Follow with a protein/carbohydrate snack (15-20gr. carbs), peanut butter & crackers or cheese & crackers
- Notify parent/guardian
- Remain with student until recovered

### Severe Low Blood Glucose

#### If you See This:

#### Student is Unconscious

- Unable to swallow
- Seizure
- **GIVE NOTHING BY MOUTH!**



#### Do This:

- Place student on side (may vomit)
- Inject Glucagon if authorized, prescribed dose \_\_\_\_\_ mg intramuscular
- **Call 911**
- Notify parent/guardian & district nurse
- Remain with student until help arrives

Parent Initials \_\_\_\_\_

Student Name \_\_\_\_\_

## ↑ High Blood Glucose – Above \_\_\_\_\_ mg/dl

### Causes

- Illness
- Underestimated carbohydrates or bolus
- Insulin pump not delivering insulin
- Excessive exercise without proper insulin
- Bad insulin
- Increased stress

### If You See Signs of High Blood Glucose

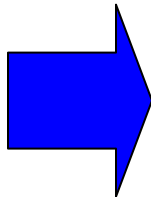
- Excessive thirst
- Frequent urination
- Hunger
- Nausea, vomiting
- Hyperactivity
- Headache
- Irritable
- Tired
- Abdominal pain
- Fatigue

### Check Blood Glucose

If Blood Glucose is:

Do This:

\_\_\_\_\_ to \_\_\_\_\_ mg/dl

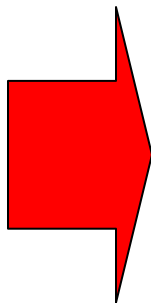


- Give correction bolus through pump (pump will calculate dose)
- Encourage increase in fluid intake (6-16oz. water per hour)
- Restrict physical activity until blood glucose is in normal range
- Recheck blood glucose in 2 hours, re-bolus if necessary
- Call parent if blood glucose is not in normal range after 2 hours

If Blood Glucose is:

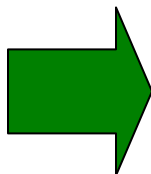
Do This:

> \_\_\_\_\_ mg/dl



- **Give correction bolus through pump** (pump will calculate dose)
- **Contact parent/guardian & district nurse**
- Encourage increase in fluid intake (6-16oz. water per hour)
- **No physical activity** until blood glucose is in normal range
- Check ketones, if moderate to large or >0.6 mmol, **call parent immediately!** Student should be sent home for parent to monitor
- Recheck blood glucose in 2 hours, if there are two consecutive blood glucose levels > \_\_\_\_\_ mg/dl:
  - **Call parent immediately**
  - May need to change the infusion set
  - May need correction dose via injection – contact parent or physician for dosage

**Vomiting, ill,  
stomachache or  
lethargic**



- Check blood glucose, give correction bolus through pump if needed
- Check ketones
- **Contact parent, student should be sent home for parent to monitor**

Parent Initials \_\_\_\_\_

Student Name \_\_\_\_\_

Supplies Needed at School			
Supplies	Needed	Provided	Not Needed
Blood glucose meter and glucose strips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lancets with lancing device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood ketone strips and meter (if using Precision meter)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine ketone strips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin syringes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibacterial skin cleaner or alcohol wipes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin pump cartridge/reservoir	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin pump infusion set	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transparent dressings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin pump batteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quick-setter/Sof-setter/Sil-setter (if used)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bottle of rapid acting insulin Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glucose tabs, Cake Mate® gel, juice, or other source of glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate snack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glucagon Emergency Kit®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Pump manual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharps container	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Copy of current basal rates and bolus dosing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pump Company Name / 24-hour Help Line Phone Number:		
MiniMed (Paradigm)	www.minimed.com	1-800-826-2099
Deltec (Cozmo)	www.cozmore.com	1-800-426-2448
Disetronic (Spirit)	www.disetronic-usa.com	1-800-688-4578
Animas	www.animascorp.com	1-877-767-7373
Omnipod	www.myomnipad.com	1-800-591-3455

Signatures			
<p>As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the diabetes tasks as outlined in this Individual Care Plan and for my child's healthcare provider to share information with the school nurse for the implementation of this plan. I understand that the information contained in this plan will be shared with staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care. Parent/guardian and student are responsible for maintaining necessary supplies, snacks, blood glucose meter, medications, and other equipment.</p>			
_____		_____	
<b>Parent Signature</b>		<b>Date</b>	
<p>We agree to implement this Individual Care Plan. We reserve the right to withdraw this Care Plan should it become a safety risk or ineffective to the health of the student. At such time the parent will be contacted and the plan will be re-evaluated.</p>			
_____		_____	
<b>School District Nurse Signature</b>	<b>Date</b>	<b>School Health Provider Signature</b>	<b>Date</b>

Revised 2/2012