Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

Part 3: Insulin Pump Supplement

Effective date: _____

To be completed by physician/provider, diabetes educator and parent/guardian.

Student Name: Date of Birth:

Pump Brand/Model: _____™ Pump Company Technical Assistance Number: _____

Pump Trainer/Resource Person: Phone/Beeper:

Child-Lock On? ☐ Yes ☐ No Code: 17 (applicable to Cozmo Deltec™ Pump only)

How long has student worn an insulin pump? _____ or

☐ **Patient is new to pump therapy and is to initiate use of pump on _____(date)**

INSULIN / PUMP SETTINGS

☐ Rapid-acting Insulin Type: _____®

☐ Use pump bolus calculator to determine all meal, snack and correction doses unless set or pump malfunction occurs.

Timing of Insulin Dose (Bolus Insulin):

Rapid-acting Insulin should always be given prior to
☐ meals ☐ snacks
if CHO intake can be predetermined.

- If CHO intake cannot be predetermined insulin should be given no more than 30 minutes after completion of meal/snack.
- Treat hypoglycemia before administration of meal or snack insulin.

Calculating Insulin Doses: According to CHO ratio and Correction Factor (if needed) - the student requires meal time coverage with rapid-acting insulin based on the amount of carbohydrates in meal and may require additional insulin to correct blood glucose to the desired range according to the following formula:

Insulin Dose = [(Actual BG – Target pre-meal BG) divided by Insulin Sensitivity] + [# carbohydrates consumed/CHO Ratio]

- Fractional amounts of insulin from correction and carbohydrate calculation, when added together, may yield an even amount of insulin
- If uneven, then round to the nearest **whole or half unit** (May use clinical discretion; if physical activity follows meal, then may round down).

Target pre-meal BG: _____ mg/dL

Insulin Sensitivity/Correction Factor:
__ unit for every _____ > target

CHO Ratio:

☐ Parent has permission to adjust CHO ratio in a range from
1:_____ to 1:_____

Exercise/PE CHO Ratio: _____ ☐ Not Applicable

- Less insulin may be required with meals prior to physical activity in order to prevent hypoglycemia. If so, the Exercise/PE CHO Ratio should be used instead of the CHO Ratio.

Extra pump supplies to be furnished by parent/guardian: ☒ infusion sets ☒ reservoirs ☐ pods for OmniPod™
☒ dressings/tape ☒ insulin ☒ syringes/insulin pen ☒ pump manufacturer instructions

STUDENT PUMP SKILLS		Comments/Additional Instructions:
1. Count carbohydrates	☐ Independent ☐ Needs Assistance	
2. Bolus for carbohydrates consumed	☐ Independent ☐ Needs Assistance	
3. Calculate and administer correction bolus	☐ Independent ☐ Needs Assistance	
4. Disconnect pump	☐ Independent ☐ Needs Assistance	
5. Reconnect pump at infusion set	☐ Independent ☐ Needs Assistance	**School nurses/personnel are not routinely trained on use of specific insulin pumps. School personnel will not perform pump operation without training (to be coordinated with school by caregiver and healthcare provider). If child is not independent and trained RN/personnel are not available, parent/guardian to be contacted for set change. Insulin by injection until set is changed per DMMP orders. If administering via injection, pump must be suspended or disconnected unless ordered otherwise.**
6. Access bolus history on pump	☐ Independent ☐ Needs Assistance	
7. Prepare reservoir and tubing	☐ Independent	
8. Insert infusion set	☐ Independent	
9. Use & programming of square/extended/dual/combo bolus features	☐ Independent ☐ Needs Assistance	
10. Use and programming of temporary basals for exercise and illness	☐ Independent ☐ Needs Assistance	
11. Give injection with syringe or pen, if needed	☐ Independent ☐ Needs Assistance	
12. Re-program pump settings if needed	☐ Independent ☐ Needs Assistance	
13. Trouble shoot alarms and malfunctions	☐ Independent ☐ Needs Assistance	

Institution Form #

Specific duration of order: **SCHOOL YEAR**	Physician/Provider Signature: : Provider Printed Name:	Office Phone: _____ Office Fax: _____ **Emergency #** _____

Institution Name and Address

DIABETES MEDICAL MANAGEMENT PLAN

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

Part 3: Insulin Pump Supplement (continued)

Student Name: **Effective Date:**

HYPOGLYCEMIA MANAGEMENT (Low Blood Glucose):

Follow instructions in DMMP, but in addition:

If seizure or unresponsiveness occurs:

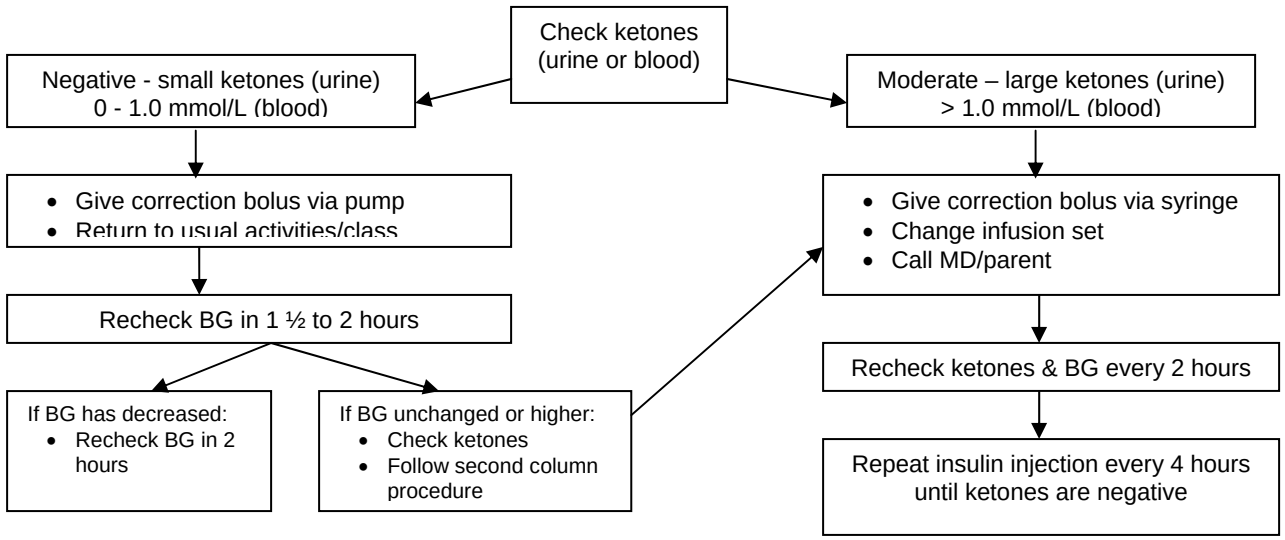
1. **Treat with Glucagon** (See Diabetes Medical Management Plan)
2. **Call 911** (or designate another individual to do so)
3. **Stop insulin pump** by any of the following methods (Send pump with EMS to hospital):
   - Placing in "suspend" or stop mode (See manufacturer's instructions)
   - Disconnecting at site, pigtail or clip
   - Cutting tubing
4. Notify parent
5. If pump was removed, send with EMS to hospital

HYPERGLYCEMIA MANAGEMENT (High Blood Glucose)

Follow instructions in diabetes medical management plan (DMMP), but in addition:

Prevention of DKA (Diabetic Ketoacidosis)

If Blood Glucose (BG) is >_____mg/dL two times in a row, drink 8-16 oz. of water/hour and follow below:



ADDITIONAL TIMES TO CONTACT PARENT/GUARDIAN

- Soreness, redness or bleeding at infusion site
- Leakage of insulin at connection to pump or infusion site
- Insulin injection given for high BG/ketones
- Dislodged infusion set
- Pump malfunction
- Repeated Alarms

Other Instructions:

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations.

School plan reviewed by:	Physician/Provider Signature: Provider Printed Name:	Date:
Acknowledged and received by:	Parent/Legal Guardian:	Date:
Acknowledged and received by:	School Representative:	Date: