

Diabetes Insulin Pump Addendum

DIABETES – Insulin Pump/Smart Pen Addendum to IHP Utah Department of Health/ Utah State Board of Education			School Year:	Picture
			Student:	DOB:
Parent:	Phone:	Email:		
School Nurse:	School Phone:	Fax or Email:		

STUDENT DIABETES MANAGEMENT SKILLS	Needs Assistance	Needs Supervision	Independent
Identifying feelings of hypoglycemia			
Checking blood glucose			
Entering information into pump			
Independently counts carbohydrates			
Entering info into pump/smart pen			

INSULIN PUMP INFORMATION		
Type of pump/Smart Pen:	Type of CGM:	Type of insulin:
Insulin to carb ratio: ___ unit for every ___ grams of carbohydrates before meals.		
Correction dose: ___ unit for every ___ mg/dl for blood glucose above ___ mg/dl.		
Times to bolus: <input type="checkbox"/> Before meals <input type="checkbox"/> After the meal <input type="checkbox"/> Other (specify):		
If Pump or Set Malfunctions: NOTIFY SCHOOL NURSE AND PARENT IMMEDIATELY. Insulin should be given by Injection		

SPECIAL CONSIDERATIONS (PE, School Parties or Snacks, Field Trips, Academic testing)
PE: <input type="checkbox"/> Check BG before PE <input type="checkbox"/> ___ gram carb (free) snack before PE <input type="checkbox"/> Other (specify):
<input type="checkbox"/> Do not exercise if BG is below ___ mg/dl or symptomatic of hyperglycemia
School parties or snacks: <input type="checkbox"/> Give insulin per pump calculations <input type="checkbox"/> Student to save snack for lunchtime
<input type="checkbox"/> No coverage for snacks/parties <input type="checkbox"/> Student to take snack home <input type="checkbox"/> Parent will provide alternate snack
<input type="checkbox"/> Other (specify):
Field Trips: Parent and school nurse must be notified of field trips in advance so proper planning and training can be accomplished.
Please specify instructions:
Academic Testing:
<input type="checkbox"/> Student may reschedule academic testing with teacher, as needed, if blood glucose is below ___ or over ___
<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Other considerations (specify):

WHEN HYPERGLYCEMIA OCCURS OTHER THAN AT LUNCHTIME
Instructions for hyperglycemia (select all that apply):
<input type="checkbox"/> Give correction dose per pump/smart pen calculation (correction doses at times other than meals per pump/smart pen calculations only)
<input type="checkbox"/> Allow unrestricted access to the bathroom
<input type="checkbox"/> Notify parent/guardian
<input type="checkbox"/> Give extra water and/or non-sugar-containing drinks (not fruit juices)

PARENT ACKNOWLEDGEMENT	
<input type="checkbox"/> I understand settings on the pump are established by the student's healthcare provider and entered by the parent/guardian. School staff will not adjust pump settings.	
<input type="checkbox"/> I understand if I adjust insulin doses delivered during school hours that I am responsible for contacting provider and requesting an updated prescriber order be sent to the school.	
Parent Signature:	Date: