DIABETES INSULIN PUMP
SCHOOL CARE PLAN

Child's Name: _____ School: _____

Grade: _____ Student #: _____ Birth date: _____

TYPE OF INSULIN PUMP:

Animas Disetronic (type: _____) MiniMed 508 Paradigm

Other: _____

TYPE OF INSULIN:

Humalog (Lispro) Novolog (Aspart)

Other (diluted or mixed insulin): _____

BLOOD GLUCOSE MONITORING:

Name of meter: _____ Time(s) of day to test: _____

Location of meter: _____ Location of where to test: _____

Does child need assistance with blood glucose monitoring? ❑ Yes ❑ No

RECOGNITION OF HYPOGLYCEMIA (LOW BLOOD GLUCOSE)

Symptoms typically seen: _____

Time of day most likely to occur: _____

Treatment of choice, provided by family: _____

Blood glucose level when treatment should be given: _____

RECOGNITION OF HYPERGLYCEMIA (HIGH BLOOD GLUCOSE)

Symptoms typically seen: _____

Correction bolus: _____ unit of insulin for every _____ points over _____ mg/dl
(Example: 1 unit of insulin for every 50 points over a blood glucose of 150 mg/dl)

At what blood glucose level should parents be called? _____

If feeling nauseated or vomiting, contact parent(s) immediately.

SCHOOL LUNCH

The student must take a bolus of insulin prior to eating lunch. The number of carbohydrates in the food is determined and then insulin given according to the insulin-carbohydrate ratio.

Insulin-carbohydrate ratio: _____ unit(s) of insulin for every _____ grams of carbohydrate (example: 1 unit of insulin for every 15 grams of carbohydrate)

SNACKS AT SCHOOL *(Snacks can be optional for students with an insulin pump)*

Does student require snacks during school hours? ❑ Yes ❑ No

If yes, specify times needed: _____

Insulin-carbohydrate ratio: _____ unit(s) of insulin for every _____ grams of carbohydrate (example: 1 unit of insulin for every 10 grams of carbohydrate)

List food items to be provided by family for snacks: _____

_____

OTHER SCHOOL PERSONNEL

Please check which other school personnel should be aware of this Diabetes Insulin Pump School Care Plan:

❑ Substitute Teachers ❑ Principal/Asst. Principal ❑ Office Staff
❑Bus Driver(s) ❑ Librarian ❑ Lunch Room Personnel
❑Classroom Representative ❑Other: _____

TROUBLESHOOTING PUMP EQUIPMENT

Contact the parent(s) and/or pump manufacturer (1-800 # located on the back of the pump) if any of the following problems occur:

Pump alarms
Blank screen
Dead batteries
Pump becomes disconnected
Empty cartridge (reservoir)

Utilize the back-up supplies (insulin, syringes, replacement infusion sets, etc.) as directed by parent(s).
Location of back-up supplies: _____

EMERGENCY TELEPHONE NUMBERS

Parent/Guardian Name: _____ Phone #: _____

Alternate Contact: _____ Phone #: _____

Pump Manufacturer: _____ Customer Service #: _____

SIGNATURES

_____ _____
Parent/Guardian Signature Date

_____ _____
School Nurse Signature Date

_____ _____
Physician Signature (required) Date