FAIRVIEW PARK CITY SCHOOLS

ADMINISTRATIVE OFFICES

21620 Mastick Road • Fairview Park, OH 44126 • P: (440) 331-5500 • F: (440) 356-3545

Dr. William W. Wagner, Superintendent • Kimberly Sperling, Treasurer

Diabetes Action Plan- Insulin Pump

Name:_____ Grade: _____ DOB: _____

Parent/ Guardian Contact- Call in order of preference:

	Name	Telephone Number	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Prescriber: _____ Phone: _____ Fax: _____

Blood Glucose Monitoring:
Meter Location- _____ Student permitted to carry meter- **[ ] Yes [ ] No**

Testing Time:
[ ] Before Breakfast/Lunch [ ]1-2 hours after lunch [ ] Before/after snack [ ] Before/after exercise
[ ] Before recess [ ] Before riding bus/walking home [ ] Always check when student is feeling high, low and during illness
[ ] Other_____

Snacks:
[ ] Please allow a _____gram snack at_____ [ ] Before/after exercise

****Snacks are provided by parent /guardian and located in _____*

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of low blood sugar or if blood sugar is below _____mg/dl
[ ] Treat with 10-15 grams of quick-acting glucose:
[ ] 4oz juice or [ ] ____ glucose tablets or [ ] Glucose Gel or [ ] Other _____
[ ] Retest blood sugar every 15 minutes, repeat treatment until blood sugar level is above target _____mg/dl
[ ] If no meal or snack within the hour give a 15 gram snack
[ ] If student unconscious or having a seizure: Give Glucagon [ ] Yes [ ] No
[ ] Amount of Glucagon to be administered: _____mg(s) IM, SC, and call 911 and parents
[ ] Notify parent/guardian for blood sugar below _____mg/dl

Treatment for Hyperglycemia /High Blood Sugar

If student showing signs of high blood sugar or if blood sugar is above _____mg/dl
[ ] Allow free access to water and bathroom
[ ] Check ketones for blood sugar over _____ mg/dl [ ] Notify parent/guardian if ketones are moderate to large
[ ] Notify parent/guardian for blood sugar over _____mg/dl
[ ] See insulin correction scale (next page)
[ ] Call 911 and parent/guardian for hyperglycemia emergency. Symptoms may include nausea &vomiting, heavy breathing, severe abdominal pain, chest pain, increased sleepiness or lethargy, or loss of consciousness.

Document all blood sugars and treatment

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Orders for Insulin Administered via Pump

Brand/Model of pump: _____ Type of insulin in pump: _____

Can student manage Insulin Pump Independently: **[ ] Yes [ ] No [ ] Needs supervision** (describe): _____

_____

Insulin to Carb Ratio: ___ units per _____grams **Correction Scale:** ____units per ____over _____mg/dl

Give lunch dose: [ ] before meals [ ] immediately after meals [ ] if blood sugar is less than 100mg/dl give after meals

Student may: [ ] Use temporary rate [ ] Use extended bolus [ ] Suspend pump for activity/lows

****If student is not able to perform above features on own, staff will only be able to suspend pump for severe lows.*

For blood sugar greater than ____mg/dl that has not decreased in ____hours after correction, consider pump failure or infusion site failure and contact parents.

For infusion set failure, contact parent/guardian: Can student change own infusion set: **[ ] Yes [ ] No**

- Student/parent insert new infusion set
- Administer insulin by pen or syringe using pump recommendation

For suspected pump failure, suspend pump and contact parent/guardian:

- Administer insulin by syringe or pen using pump recommendation

Continuous Glucose Monitor (CGM)

[ ] Student not using CGM

Name of CGM: _____

Alert for Low blood glucose _____mg/dl Alert for High blood glucose _____mg/dl

[ ] Verify all alarms with blood glucose finger stick before treatments
Do not disconnect CGM for sports of activities
If adhesive is peeling off reinforce with medical tape
If CGM falls off do not throw pieces away, place in a bag, contact and return to parents
Insulin injections should be at last 3 inches away from CGM device
Do not give Tylenol while using the CGM
Other instructions from MD regarding using CGM for insulin dosing: **[ ] Yes [ ] No**

Activities/Skills	**Independent**	
Blood Glucose Monitoring	Yes	No
Carbohydrate Counting	Yes	No
Selection of snacks and meals	Yes	No
Treatment for mild hypoglycemia	Yes	No
Test urine/blood for ketones	Yes	No
Management of Insulin Pump	Yes	No
Management of CGM	Yes	No

Authorization for the Release of Information:

I hereby give permission for _____ (school) to exchange specific, confidential medical information with _____ (Diabetes healthcare provider) on my child _____, to develop more effective ways of providing for the healthcare needs of my child at school.

Prescriber Signature_____Date_____

Parent Signature_____Date_____