Anchorage School District

Diabetes Pump Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

Student Photo

EQUIPMENT *(provided by parent/guardian to school nurse)*

☐ **Pump** *Model* _____ *Insulin* _____ *Basal Rate* _____ *Mode* _____

☐ **CGM** *Type* _____ ☐ Backup Glucometer ☐ Glucometer strips ☐ Lancets

☐ Snacks *(fast acting carbs, protein)* ☐ Ketone test strips ☐ Emergency meds ☐ Other: _____

SCHEDULED CARE

Step 1. Blood Glucose Correction (BGC) Insulin Dose

Check Current Blood Glucose and give BGC Dose ☐ *May use CGM for BGC dosing*

☐ Before Breakfast ☐ Before Lunch ☐ Per Pump ☐ Other: _____

☐ Insulin dosing per pump recommendations.

☐ Verify pump settings for:
Target Blood Glucose: _____
Insulin Sensitivity Factor: _____

☐ Using the following parameters and formula:

Target Blood Glucose: _____ mg/dL Insulin Sensitivity Factor: _____

$$\frac{\textbf{(Current BG - Target BG)}}{\textbf{Insulin Sensitivity Factor}} = \_\_\_\_\_ \textbf{ Units of Insulin}$$

DO NOT GIVE BGC MORE THAN ONCE EVERY THREE HOURS

Step 2. Carbohydrate Coverage Insulin Dose

Calculate Carbohydrate Intake ☐ Before consuming carbs ☐ After consuming carbs

And give Carbohydrate Coverage Insulin Dose for:

☐ All carb intake ☐ Breakfast ☐ Lunch ☐ Snacks ☐ Per Pump ☐ Other: _____

☐ Using the built-in carb coverage ratio input.

☐ Verify pump Insulin/Carb ratios:

Time/Meal: _____ Ratio: ___:___
Time/Meal: _____ Ratio: ___:___
Time/Meal: _____ Ratio: ___:___
Time/Meal: _____ Ratio: ___:___
Time/Meal: _____ Ratio: ___:___

☐ Using the following parameters and formula:

Time/Meal: _____ 1 U Insulin per _____ grams of CHO
Time/Meal: _____ 1 U Insulin per _____ grams of CHO
Time/Meal: _____ 1 U Insulin per _____ grams of CHO
Time/Meal: _____ 1 U Insulin per _____ grams of CHO

$$\frac{\textbf{Total grams of Carbohydrates to be eaten}}{\textbf{Grams of CHO per 1 unit of insulin}} = \_\_\_\_\_ \textbf{ Units of Insulin}$$

☐ If BG <70 before a meal, follow Algorithms for Blood Glucose Results.

Step 3. BGC + Carbohydrate Coverage = Insulin Dose

☐ Input the Blood Glucose and Carbohydrates to be consumed into the pump

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PRN CARE

Check Blood Glucose using CGM

☐ Before Exercise/PE/Gym/Recess ☐ After Exercise/PE/Gym/Recess ☐ Before leaving school

Check Blood Glucose using Glucometer

☐ For signs and symptoms of hyper/hypoglycemia ☐ To confirm hypo- or hyperglycemia

☐ CGM indicates rapid change prior to BGC dose ☐ To calibrate CGM ☐ Other: _____

Check Ketones

☐ For BG >250 mg/dL, repeat in 2 hours. If still >250 mg/dL, check urine ketones and refer to Algorithm.

☐ For signs of DKA ("three P's" - polyuria, polydipsia, polyphagia, abdominal pain, vomiting)

Exercise/PE/Gym/Recess

A quick-acting source of glucose such as a glucose tab or sugar-containing juice should be available at the site of the physical activity.

☐ Student should eat _____ grams of CHO ☐ Before ☐ Q30min ☐ Q1H ☐ After activity

☐ If pre-exercise blood glucose is **less than 70 mg/dL**, student can participate in physical activity once blood glucose is corrected and **above 120 mg/dL**.

☐ If pre-exercise blood glucose is **less than 120 mg/dL**, student can participate in physical activity once they **consume 15 grams** CHO with protein.

☐ If student is to exercise right after lunch, student should subtract ____ gm from their Carbohydrate coverage.

☐ Turn on Activity Mode

☐ Decrease Temp Basal Rate by ☐ ___ % ☐ ___ units for ____ min ☐ Duration of exercise.

☐ Activate Temp Target BG for ☐ _____ min before ☐ _____ min after ☐ Duration of exercise.

☐ May disconnect from the pump for exercise, but no longer than 2 hours.

☐ Student should monitor blood glucose hourly.

Other Care

☐ Yes ☐ No Parents/Guardians are allowed to adjust insulin doses 20% higher or lower.

☐ Yes ☐ No Pump settings should not be changed, unless directed by the ordering provider.

☐ Yes ☐ No Suspend pump when BG <70 mg/dL and reactivate at 85 mg/dL

If infusion set comes out or fails: ☐ Change set at school ☐ Follow BCG every three (3) hours

OTHER MEDICATION

☐ Tresiba (Insulin glargine) _____ units SQ DAILY to be witnessed or performed by nurse or trained staff.

☐ Fast-acting insulin _____ if pump set comes out and follow BCG and Carb Coverage orders.

☐ Baqsimi 3 mg Intranasal PRN for hypoglycemia <70 and unable to swallow. Recheck BG in 15 min and if <70, give a second dose and call 911.

☐ Glucagon ____ mg IM or SQ PRN for hypoglycemia <70 and unable to swallow. Recheck BG in 15 min and if <70, call 911.

NOTES

MEDICAL PROVIDER SIGNATURE	***DATE***

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THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH

Medical Provider Assessment of Student's Diabetes Management Skills

Skill	Independent	With Supervision*	Cannot Do	Notes
Check Blood Glucose	☐	☐	☐	
Count carbohydrates	☐	☐	☐	
Calculate insulin dose	☐	☐	☐	
Insulin administration	☐	☐	☐	
Troubleshoot CGM alarms	☐	☐	☐	
Troubleshoot Pump alarms	☐	☐	☐	
Set Temp Basal/Temp Target	☐	☐	☐	
Change infusion set	☐	☐	☐	

**The nurse or other trained staff are expected to observe for accuracy and completion of skills "with supervision."*

MEDICAL PROVIDER NAME/TITLE	***PHONE***	***EMAIL***
MEDICAL PROVIDER SIGNATURE		***DATE***

PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that the medication(s) and diabetes care outlined on this plan be given to my child. I will provide needed medications or supplies for care in school.

Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success.

I understand that ANY remaining diabetes care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the ASD school year calendar.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

PARENT/GUARDIAN NAME	***RELATIONSHIP TO STUDENT***	***PHONE NUMBER***
PARENT/GUARDIAN SIGNATURE		***DATE***

NURSE PLAN REVIEW

I have reviewed the Diabetes Pump Care Plan for accuracy and ensure that all required fields and signatures are completed before providing care to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME	
NURSE SIGNATURE	***DATE***