SCHOOL DIABETES ORDERS – HYBRID CLOSED LOOP INSULIN PUMP

Licensed Healthcare Provider (LHP) to Complete Annually

NAME: ______________________________SCHOOL: __________________ GRADE: __________

Start date: _______________for __________school year ☒ Through last day of school ☐ Other:

LOW BLOOD GLUCOSE (BG) MANAGEMENT

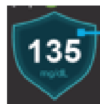
7. If BG is below 70 or having symptoms, give _______ grams fast-acting carbohydrate (i.e. 4 glucose tabs, 4 oz juice).
8. Recheck BG in 15 minutes and repeat carbohydrate treatment if BG still < 80 or if child continues to be symptomatic.
9. Once BG is > 80, may follow with 10-15 gram carb snack, or meal if time. Do not include low treatment in meal carbs.

If unconscious, unresponsive, difficulty swallowing, or evidence of seizure: Phone 911 immediately. Do NOT give anything by mouth.

☒ **If nurse or trained PDA is available, administer Glucagon _______ mg SQ or IM -or- Baqsimi 3mg/nasal spray**

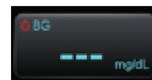
HIGH BLOOD GLUCOSE (BG) MANAGEMENT

AUTO MODE (Blue Shield)



SAFE BASAL (Grey Shield)

MANUAL MODE



☒ If BG is over 150 and pump recommends corrective insulin dosing. Administer recommended dose (Pump will account for insulin on board)

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☐ If BG is over 250 for 2 hours after last bolus or carbohydrate intake. administer recommended dose. (Pump will account for insulin on board).

9. Ketones: Test urine ketones if ☒ BG > 300 X 2hrs, or ☐ Never. Call parent if child is having moderate or large ketones.
10. No exercise if having nausea or abdominal pain, or if ketones are tested and found positive (moderate or large).
11. Encourage student to drink plenty of water and provide rest if needed.

BLOOD GLUCOSE TESTING

BG to be tested: ☒ Before meals and for symptoms of low or high BG, or as set up by the 504 plan

Extra BG testing: ☒ When the pump requested a blood glucose check to stay in Auto Mode.

☐ before exercise, ☐ before PE, ☒ before going home, ☒ other: as needed/requested by student

Blood sugar at which parents should be notified: Low < 70 mg/dL after 2 treatments, or High >300 mg/dL X 2 hours

Notify the parents if repeated hypoglycemia, abdominal pain, nausea/vomiting, fever, if hypoglycemic before going home, or if there is a refusal of care by the student. Hyperglycemia alone is not medically justified for sending home @FNAME@, in absence of symptoms.

SENSOR CALIBRATIONS

☒ Calibrate before lunch daily – Do not calibrate if there are double or triple arrow up or down

☒ When the pump requests a calibration (this is required to stay in Auto Mode)

*The Medtronic CGM sensor is required for the pump to function in Auto Mode.

*The Medtronic 670G pump can be used without the sensor as a Manual Mode pump (traditional pump, like previous pump systems)

INSULIN ADMINISTRATION at *Mealtime/Snacks* ☐ Apidra ☐ Humalog ☐ Novolog ☐ FIASP

Pump Brand: Medtronic 670G

AUTO MODE

Insulin dosing to be given: ☒ **before meal (mandatory)**

Insulin to Carb Ratio: 1 unit per _______ grams Carb (In auto mode you *cannot* override recommended bolus)

BG Correction Factor: Automatically adjusted by pump

Basal Rates: Basal rates are automatically adjusted by pump every 5 minutes

MANUAL MODE

Insulin to Carb Ratio: 1 unit per _______ grams Carb

BG Correction Factor: 1 unit per _______ mg/dL > _______

Basal Rates: Basals adjusted per parents and HCP

☒ Parent/caregiver authorized to adjust insulin for carbs, BG level, or anticipated activity

Pre-meal BG target: ☒ 70 - _____, or ☐ Other:

Insulin dosing to be given: ☐ before, or ☐ after meal

☒ insulin & syringe should be used for pump malfunction

☒ after meal dosing when before meal BG < 80 mg/dL

☒ Licensed medical personnel authorized to adjust the insulin dose by +/- 0 to 5 units after consultation with parent/caregiver

STUDENT'S SELF-CARE

1.	Totally independent diabetes management	☐	**4.**	Student consults with nurse/PDA for insulin dose **or**	☐
2.	Student needs BG/SG verification of number by nurse/PDA/designated staff **or**	☐		Student self-injects insulin with nurse/PDA/ designated staff supervision only **or**	☐
	Assist BG testing to be done by nurse/PDA	☐		Injection to be done by school nurse/PDA	☐
3.	Student consults with nurse/PDA/designated staff for carbohydrate count	☐			

If patient wears **Dexcom G5, G6 or FreeStyle Libre** CGM insulin dose per orders based on SG reading per FDA. Test BG if no number, no arrow trend, or if symptoms/expectations do not correlate with SG reading.	If patient wears **Medtronic Guardian Connect** CGM; Insulin per orders based on BG reading only per FDA.

DISASTER PLAN & ORDERS

Parent is responsible for providing and maintaining "disaster kit" and to notify school nurse. In case of disaster:

Use above BG correction scale + carb ratio coverage for disaster insulin dosing every 3-4 hrs.

Electronically signed by: ____ Date: ____________________ Fax: ___________________

☐ I authorize the exchange of medical information about my child's diabetes management between the LHP and the school nurse

Parent Signature:_________________________________ Print Name:_____________________________ Date:_____________

School Nurse Signature:____________________________ Print Name:_____________________________ Date:______________

Revised 5.2020

PARENT/GUARDIAN SECTION

EMERGENCY CONTACTS

Name
Home Phone
Work Phone
Other

Name
Home Phone
Work Phone
Other

ADDITIONAL EMERGENCY CONTACTS:

1.	Relationship:	Phone:
2.	Relationship:	Phone:

****Does the student need classroom, school activity, or recess accommodations? ___yes ___no. If yes, please contact the school counselor.**

- A new health care plan for health conditions must be submitted each school year.
- I understand that if any changes are needed on the HCP, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other non-school programs of their child's health condition.
- Medical information may be shared with school staff working with your child and 911 staff, if they are called.
- I have reviewed the information on this health care plan and request/authorize trained school employees to provide this care in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I understand this plan can only be discontinued by the LHP.
- I authorize the exchange of information about my child's health condition between the LHP office and the school nurse.
- *My signature below shows I have reviewed and agree with this health care plan.*

Parent/Guardian Signature Date

For District Nurse's Use Only		
School Nurse Signature	**Date**	**Phone:**

Health care plan and medication (if prescribed) must accompany student on any field trip or school activity.

*****Keep plan readily available for <u>substitutes</u>.*****