

SCHOOL DIABETES ORDERS – HYBRID CLOSED LOOP INSULIN PUMP

Licensed Healthcare Provider (LHP) to Complete Annually

NAME: _____ SCHOOL: _____ GRADE: _____

Start date: _____ for 2020-2021 school year Through last day of school Other: _____

LOW BLOOD GLUCOSE (BG) MANAGEMENT

- If BG is below 70 or having symptoms, give _____ grams fast-acting carbohydrate (i.e. 4 glucose tabs, 4 oz juice).
- Recheck BG in 15 minutes and repeat carbohydrate treatment if BG still < 80 or if child continues to be symptomatic.
- 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.**

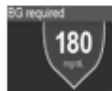
If nurse or trained PDA is available, administer Glucagon _____ mg SQ or IM -or- Baqsimi 3mg/nasal spray

HIGH BLOOD GLUCOSE (BG) MANAGEMENT

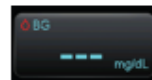
AUTO MODE
(Blue Shield)



SAFE BASAL
(Grey Shield)



MANUAL MODE



- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> If BG is over 150 and pump recommends corrective insulin dosing. Administer recommended dose (Pump will account for insulin on board) | <input checked="" type="checkbox"/> If BG is over 150 and pump recommends corrective insulin dosing. Administer recommended dose. (Pump will account for insulin on board) | <input type="checkbox"/> If BG is over 250 for 2 hours after last bolus or carbohydrate intake. administer recommended dose. (Pump will account for insulin on board). |
|---|--|--|

- Ketones: Test urine ketones if BG > 300 X 2hrs, or Never. Call parent if child is having moderate or large ketones.
- No exercise if having nausea or abdominal pain, or if ketones are tested and found positive (moderate or large).
- 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

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

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

STUDENT'S SELF-CARE

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