



**2019-2020 Personal Diabetes Medical Management Plan on PUMP**

Please complete **ALL BLANK AREAS**.

*YOU WILL BE RESPONSIBLE FOR GETTING THIS PLAN TO YOUR CHILD'S SCHOOL*

For provider signature, please fax form to # **317-948-2760** or email to **diabhelp@iupui.edu** or

**mail** to ATTN: Riley Hospital Diabetes Team

705 Riley Hospital Drive, Room #5960, Indianapolis IN 46202.

**\*\*ALLOW 1-2 WEEKS TO PROCESS \*\***

**Date Form Completed:** \_\_\_\_\_ **Date School Starts:** \_\_\_\_\_

**Diabetes Physician's Name:** \_\_\_\_\_

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Type of Diabetes:**  Type 1  Type 2  Other:  \_\_\_\_\_

**Parent Name & Contact Number:** \_\_\_\_\_

**Parent Email:** \_\_\_\_\_

**Name of School and City:** \_\_\_\_\_

**School Phone Number:** \_\_\_\_\_ **Fax Number** \_\_\_\_\_

**School's Nurse E-mail:** \_\_\_\_\_

**1. BLOOD SUGAR CHECKS:**

**\*\*Please send blood sugar records to parents weekly. Do not send routine records to Riley unless requested**

Please check student's blood sugar daily:

- before all meals ( breakfast/lunch)
- if student feels/acts hypoglycemic
- if student is ill
- as described in the individualized health plan determined by school nurse and parent.

If blood sugar is below **70 (80 if under 6 years of age)** (see "Hypoglycemia" section).

If **BS >250**, see "Hyperglycemia" section.

► **Does child wear a continuous glucose monitor (CGM)?**  YES  NO

► **If yes, which brand?** \_\_\_\_\_

► **Does child dose/treat lows based on the CGM reading?**  YES  NO

Refer to page 5 for guidelines on CGM use.



2. **STUDENT'S LEVEL OF SELF-CARE** *Supervision means nurse will supervise task.*

Test blood sugar No supervision Needs supervision Adult to do

Treat mild low blood sugars No supervision Needs supervision Adult to do

Calculate/count carbs eaten at meal/snack No supervision Needs supervision Adult to do

Check ketones No supervision Needs supervision Adult to do

Administer bolus doses on pump No supervision Needs supervision Adult to do

Prepare reservoir and tubing or pod No supervision Needs supervision Adult to do

Give injections with syringe or pen, if needed No supervision Needs supervision Adult to do

Change infusion set or pod No supervision Needs supervision Adult to do

Troubleshoot pump alarms and malfunctions No supervision Needs supervision Adult to do

3. **MEAL PLAN:** Carb amounts can vary, **scheduled meals and snacks must be at least 2 hours apart.** For special circumstances such as class parties please call parents or Riley Diabetes Team

**Amount of carbohydrates will vary unless child is on carb limits indicated below**

Breakfast: \_\_\_\_\_ AM Snack: \_\_\_\_\_ Lunch: \_\_\_\_\_ PM Snack: \_\_\_\_\_

4. **INSULIN DOSE:** **Nurse/volunteer health aide should allow the pump to calculate the insulin dose and should not alter the dose reported on the pump without first consulting the health care provider.**

5. **HYPOGLYCEMIA:** please treat hypoglycemia if blood sugar is less than **70 (80 if under 6 years of age)**

**\*\* NEVER send a student with actual or suspected low blood sugar anywhere alone \*\***

- Give 15 grams of a fast acting carb (ex. 4 oz fruit juice or regular soda, 4 glucose tabs, glucose gel). If blood sugar is less than 50 please give 30 grams of a fast acting carb.
  - Recheck blood sugar in 15 minutes and repeat treatment until BS is above **70 (80 if under 6 years of age)**. *No follow-up snack needed unless specified by parent/HCP.*
  - Student should not participate in exercise-related activity or go to meal until BS is at or above **70 (80 if under 6 years of age)**.
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- If **UNCONSCIOUS** or **SEIZING**, or **if directly instructed to by diabetes provider** **ADMINISTER 1 Vial (1/2 Vial** if less than 6 years of age) of GLUCAGON (IM injection). Suspend or disconnect pump.
- If student remains low after three treatments, please call the Riley Diabetes ER line for further instructions.

**6. HYPERGLYCEMIA MANAGEMENT:** if blood sugar is greater than 250, check urine (or blood) for ketones and follow “Hyperglycemia Decision Flowsheet” on page 4.

- If using blood ketones:
  - Negative ketones = <0.6
  - Trace or Small ketones = 0.6-1.0
  - Moderate or Large = >1.0

**7. ILLNESS:** If student is vomiting, complaining of nausea, or otherwise ill please check ketones and call Riley Diabetes Team for questions.

**8. RILEY HOSPITAL EMERGENCY CONTACT:**

- If you need to speak to the Riley Diabetes Team right away (student vomiting, unsure of insulin dose, low blood sugar not responding to treatment, moderate/large ketones) please call the emergency line.
- **Emergency Line:**  
**Call 317-944-5000 and ask for the Pediatric Diabetes Practitioner on-call**

**9. DETAILED MANAGEMENT PLAN INFORMATION:**

For detailed management guidelines and additional accommodations a child with diabetes may need including snacks, restroom privileges, and supervision with daily care, please access <https://www.rileychildrens.org/departments/diabetes-endocrinology> (scroll down to resources and “Information about Injections” or “Information about Pump Therapy”)

**10. EXERCISE:**

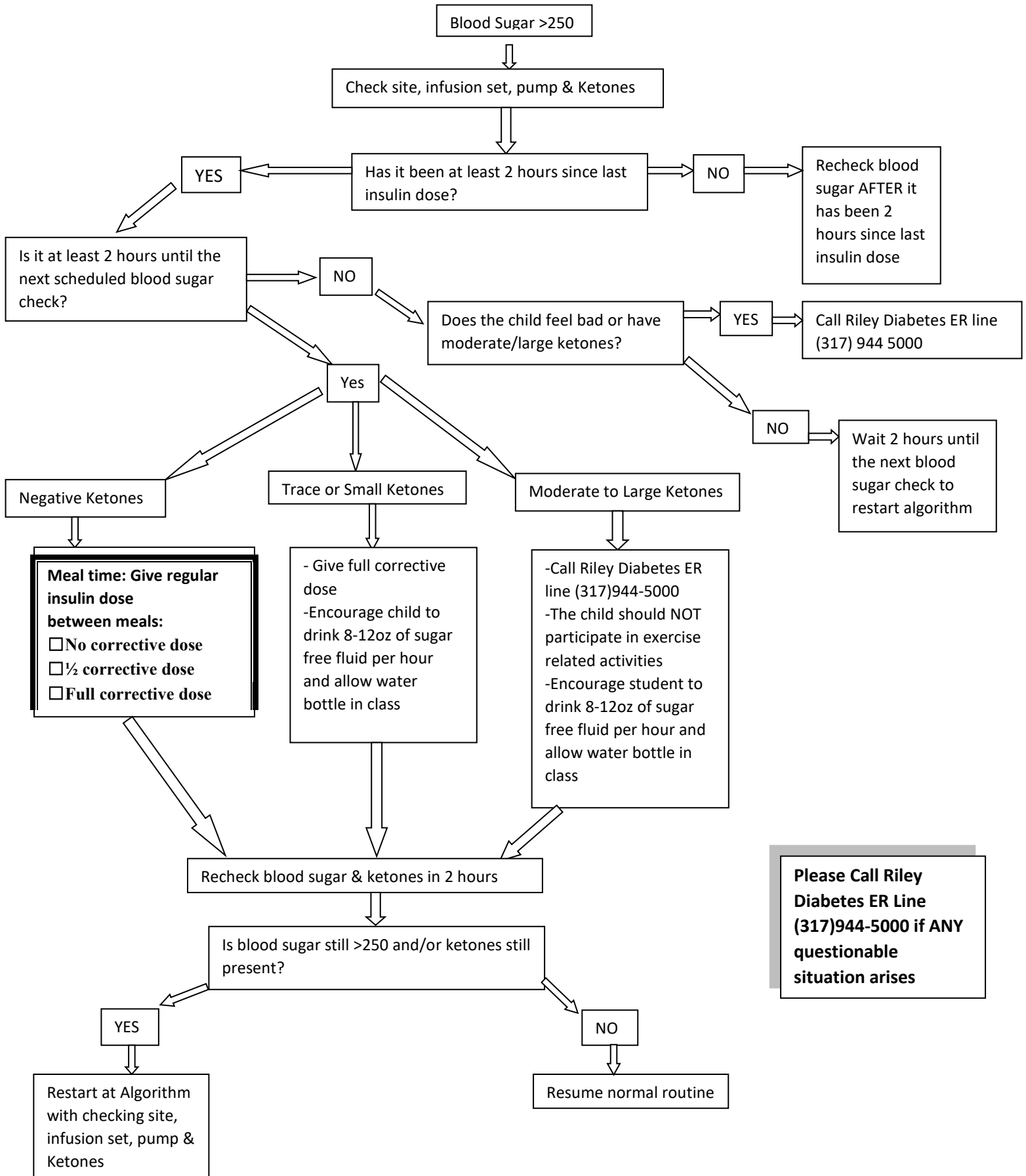
- Child may disconnect or suspend pump for PE if parent wishes. Most children on pumps do not require a snack prior to activity. Nurse and parent need to discuss and decide if child should eat a snack pre PE or recess.

**11. ADDITIONAL ORDERS:**

Click here to enter text.



### Pump Hyperglycemia Decision Flowsheet



**Please Call Riley Diabetes ER Line (317)944-5000 if ANY questionable situation arises**



### Information about Continuous Glucose Sensors (CGM):

- A CGM measures glucose in interstitial fluid around the blood vessels every 5 minutes
- A sensor glucose is displayed on the screen of the insulin pump or separate device every 5 minutes
- The purpose is to identify trends in glucose variation as well as alert for impending high or low sensor glucose
- The sensor will display arrows up or down if sensor glucose is rising or falling
- There can be a 15-20 percent difference between sensor glucose and blood glucose

**The FDA has approved the following devices to be used for insulin dosing: Dexcom G5, Dexcom G6, and the Freestyle Libre.**

Guidelines that need to be followed if using the CGM for dosing with insulin or treating a low:

<b>Must have:</b>	<b>Dexcom G5</b>	<b>Dexcom G6</b>	<b>Freestyle Libre</b>
Sensor glucose with number and arrow to dose from	Yes	Yes	Yes
No Acetaminophen (Tylenol) taken in past 24hrs	Yes	No	No
At least 2 hours since last correction and food dose given for high sugar	Yes	Yes	Yes

We recommend that the minimum numbers of alarms are set during the school day. If predictive lows are set please discuss with parent how these should be handled. We recommend leaving high alerts off at school (except if on pump then the high alerts should be set at 250). If high alerts are set a corrective dose can only be given in-between meals if it has been at least 2 hours since the last insulin dose and there is at least 2 hours until the next meal. There also must be an order for a corrective dose to be given in between meals.

There **ALWAYS** needs to be a blood glucose meter available.

If symptoms do not match sensor glucose. **ALWAYS** test blood glucose for treatment

**ALWAYS** record sensor glucose when being used for treatment of low sensor glucose or for a correction dose. **Note:** There is a lag time with continuous glucose monitors. If treating a low from the Dexcom, wait 15mins and if Dex is still reading low, verify with fingerstick before treating a second time.

**ALWAYS** record glucose values used for meals in the student's pump or written log to be used for future insulin adjustments.

If student uses a cell phone, tablet or i-device with their CGM, they must be allowed to carry it with them at all times.



## Authorization to Release and Disclose Patient Information

By signing this authorization, I am allowing my student’s health care practitioner and/or organization to release my student’s medical information to the school. I understand that the health care practitioner will directly release to the school a diabetes management and treatment plan, and may answer other questions for the school as necessary for the treatment and care of my student while in the care of the school. This information may be released throughout the year whenever a change to the management and treatment plan is required. I also understand that the health care practitioner will rely on the information I provide regarding the name and contact information for the school. The following conditions apply:

- This authorization will expire at the end of the designated school year unless otherwise specified.
- I understand that I have a right to revoke this authorization at any time. In order to revoke this authorization,
- I must do so in writing and present my written revocation to health care organization. The revocation will not apply to information that has already been released in response to this authorization.
- I understand that I am not required to sign this Authorization in order to receive health care treatment.
- The health care practitioner and/or organization cannot prevent disclosure of your information by the person or organization who receives your records under this Authorization and that information may not be covered by state and federal privacy protections after it is released. By signing this Authorization, you release the health care practitioner and/or organization from any and all liability resulting from a disclosure by the recipient.

Your signature indicates that you have read and understand this form and agree to the school orders attached, and you authorize the release of the information as described above.

### 12. PARENT PLEASE SIGN (once reviewed):

\_\_\_\_\_  
Parent’s Signature

\_\_\_\_\_  
Date Signed

### 13. LICENSED HEALTH CARE PRACTITIONER:

\_\_\_\_\_  
Provider’s Signature

\_\_\_\_\_  
Date Signed

(p) 317-944-0274

(f) 317-948-2760

(e) diabhhelp@iupui.edu