

GASTON COUNTY SCHOOLS
PHYSICIAN ORDER AND TREATMENT PLAN FOR STUDENT WITH TYPE 1 DIABETES (PUMP)

STUDENT'S NAME _____ BIRTHDATE _____ DATE _____

BLOOD SUGAR MONITORING

Target range of blood sugar: _____ to _____ Type of Meter _____ Log book kept at school? Yes No
What help needed with blood sugar testing? _____ Times to test blood sugar: _____
Call parent if blood sugar is higher than _____ or lower than _____.

INSULIN PUMP INSTRUCTIONS

Type of pump: _____ Type of insulin in pump: _____
Insulin/carbohydrate ratio for meals and snacks: _____ units for every _____ carbohydrates.
Back up means of insulin administration: _____ and location: _____.

PUMP:

Does student know how to:

Operate without assistance? Y N
Change infusion site, tubing, batteries, insulin cartridge? Y N
Determine bolus amount? Y N
Give bolus? Y N
Handle and dispose of needles safely? Y N

BACKUP INSULIN INJECTIONS :

Does student know how to:

Give own injections? Y N
Determine correct insulin dose? Y N
Draw up correct insulin dose? Y N
Handle and dispose of needles safely? Y N

TREATMENT FOR HIGH BLOOD SUGAR (HYPERGLYCEMIA)

To correct high blood sugar, give insulin: _____ units for every _____ via pump.
Correction Times: _____. **Do not correct more frequently than every _____ hours.**
Student should check for urine ketones if blood sugar is above _____, or if student has nausea and vomiting.
Check blood sugar again in _____ and at _____ intervals.

TREATMENT FOR LOW BLOOD SUGAR (HYPOGLYCEMIA)

Type and amount of fast sugar to be given: _____
If symptoms do not improve in _____ minutes, give fast sugar again.
When symptoms improve, provide an additional snack of _____.
Check blood sugar level every _____ minutes until it is above _____.
Give glucagon (if ordered) if student becomes unconscious, has a seizure or is unable to swallow.
Glucagon ordered? YES NO Glucagon dosage: _____

FOOD AND EXERCISE

Recommended carbohydrates for meals: _____ Snacks: _____
Student should not exercise if blood sugar is below _____ mg/dl or above _____ mg/dl, or if (+) ketones.
Other exercise/activity instructions: _____.

Signatures

My signature below provides authorization for the above written orders and will assist the school nurse in developing an Individualized Health Plan. I understand that all procedures will be implemented in accordance with physician's orders, state laws, and regulations and may be performed by appropriately trained staff.

Physician _____

Date _____

Reviewed by:

Parent _____

Date _____

School Nurse _____

Date _____

Revised 5-14