Gaston County School Nursing Program
Physician's Orders and Treatment Plan Type I Diabetes - Pump

Date:			
Student Name:		**DOB:**	
Teacher/Grade:		**Bus:**	
Parent/Guardian Name:		**Phone:**	
Emergency Contact:		**Phone:**	
Physician's Name:		**Phone:**	

BLOOD SUGAR MONITORING

Target range of blood sugar: ____to____. Type of Meter__________________________.

What help needed with blood sugar testing? _______________. Times to test: _______________.
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

Student Name:		**DOB:**	

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:____________________________.

<u>**Signatures**</u>

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 Signature: ____ **Date:** ________________________

<u>Reviewed by:</u>

Parent Signature: ____ **Date:** ________________________

School Nurse Signature: ____ **Date:** ________________________