Maryland State Supplemental Form for Students with Insulin Pumps

This order is valid only for the Current School Year:______ (including summer session)

Student: ________________________________ **DOB:** ____________________

School: _________________________________ **Grade:** __________

CONTACT INFORMATION:

Parent/Guardian: _____________________ Home Phone: __________ Work: __________ Cell/pager: ___________

Parent/Guardian: _____________________ Home Phone: __________ Work: __________ Cell/pager: ___________

Pump Resource Person: ______________________ Phone: ______________________________

Other Emergency Contact: __________________________________

Pump Management

Type of pump: ______________________ Start Date for Pump Therapy: __________________________

Type of Insulin in pump: _________________________

Basal rates: ____________ 12am to ___________ Comment: ____________________

_____________ _______ ___________

_____________ _______ ___________

_____________ _______ ___________

_____________ _______ ___________

Insulin/carbohydrate ratio: _______ Check Management of Diabetes at School Order or correction factor

Hyperglycemia:

____ Pump site should be changed if BG greater than _____________ times _______________

____ Insulin should be given by syringe or pen if needed ________________________________

Management Skills of Student

- As verified by school nurse, health care provider and parent

	Independent?	
Count carbohydrates	__ yes	__ no
Calculate an insulin dose	__ yes	__ no
Bolus an insulin dose	__ yes	__ no
Reset basal rate profiles	__ yes	__ no
Set a temporary basal rate	__ yes	__ no
Disconnect pump	__ yes	__ no
Reconnect pump at infusion set	__ yes	__ no
Prepare infusion set for insertion	__ yes	__ no
Insert infusion set	__ yes	__ no
Troubleshoot alarms and malfunctions	__yes	__ no
Give self injection if needed	__ yes	__ no
Change batteries	__ yes	__ no

__ Student is non independent Child Lock On? Yes No

Pump Supplies

Extra supplies needed include: Infusion sets, reservoir/cartridges, insertion device, insulin vial & syringes, batteries

Location of supplies: ____

Disaster Plan (If needed for lockdown, etc):

- ☐ Follow Insulin orders as on Management Form
- ☐ Insulin doses as follows: ________________________

Other: ____

Health Care Providers Signature: _________________________________ **Date:** _________________

Parent's Signature: ____ **Date:** _________________

Order reviewed by School Nurse (per local policy): **Date:** _________________