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:_____