

FOR PATIENTS USING INSULIN PUMP THERAPY

We **MUST** receive completed form in order to complete a Personal Diabetes Medical Management Plan for your child for the 2011-2012 school year.
 Fax **COMPLETED** form to **FAX # 317-948-2760** or mail to **ATTN: Diabetes Nurse Practitioners, c/o Riley Hospital for Children,**
 705 Riley Hospital Drive, Room #5960, Indianapolis IN 46202.

Date Form Completed: _____ Date School Starts: _____
 Student Name: _____ DOB: _____ Parent Name & Phone number: _____
 Diabetes Physician _____ Nurse Practitioner _____
 Name of School and city located: _____
 School Fax Number: _____ School Phone Number _____

1. BLOOD SUGAR CHECKS AT SCHOOL: we will ask school personnel to check student's blood sugar *before all meals* (breakfast/lunch), if student *feels/acts hypoglycemic*, or if student is *ill*.

ADDITIONAL BS checks required: no additional checks needed before snacks before gym/recess
 after gym/recess before getting on bus other: _____

2. SELF CARE AT SCHOOL: (please only check one box per line)

- ▶ Child can carry their diabetic supplies with them yes no
- 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
- Disconnect & reconnect pump if needed no supervision needs supervision Adult to do
- Prepare reservoir and tubing no supervision needs supervision Adult to do
- Insert new infusion set no supervision needs supervision Adult to do
- Give injection with syringe or pen, if needed no supervision needs supervision Adult to do
- Troubleshoot pump alarms and malfunctions no supervision needs supervision Adult to do

3. INSULIN DOSES & SCHOOL MEALS/SNACKS:

Type of pump: _____ Type of Insulin: Novolog Humalog Apidra

Does your child eat the following meals at school? (please fill in current insulin doses for **ALL** times below)

	<u>Time</u>	<u>Food Dose</u>	<u>Corrective Dose</u>
Breakfast	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	1 unit: _____ grams carb	(Blood Sugar - _____) ÷ _____
AM snack	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	1 unit: _____ grams carb	(Blood Sugar - _____) ÷ _____
Lunch	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	1 unit: _____ grams carb	(Blood Sugar - _____) ÷ _____
PM snack	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	1 unit: _____ grams carb	(Blood Sugar - _____) ÷ _____
Dinner	_____	1 unit: _____ grams carb	(Blood Sugar - _____) ÷ _____
Bedtime	_____	1 unit: _____ grams carb	(Blood Sugar - _____) ÷ _____

Basal Rates: (please fill in **ALL** current basal rates below)

_____ 12am	_____ 6am	_____ 12pm	_____ 6pm
_____ 1am	_____ 7am	_____ 1pm	_____ 7pm
_____ 2am	_____ 8am	_____ 2pm	_____ 8pm
_____ 3am	_____ 9am	_____ 3pm	_____ 9pm
_____ 4am	_____ 10am	_____ 4pm	_____ 10pm
_____ 5am	_____ 11am	_____ 5pm	_____ 11pm