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:
<u>Does student know how to:</u>
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 :
<u>Does student know how to:</u>
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: ____.

<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__________________________________ **Date**__________________________________

<u>Reviewed by:</u>
Parent____________________________________ **Date**__________________________________

School Nurse________________________________ **Date**__________________________________

Revised 5-14