Everett Public Schools
Health Services

Blood Sugar at which parent/guardian should be notified:
Low: _____ High: _____

DIABETIC LHCP INSULIN PUMP AUTHORIZATION/ORDER (RCW28A.210.320)

For Seizure or Loss of Consciousness: 911 and cut tube to stop pump. Send insulin pump with EMS.

Student's Name: _____ DOB: _____ ID#: _____ Grade: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

LHCP: _____ Office name: _____ Phone: _____ FAX: _____

How long has student been on insulin pump therapy? ☐ 0-6 months ☐ 6-12 months ☐ 1-2 years ☐ 2+ years

Type of insulin in pump: _____ **Pump brand/model:** _____ **Child lock on?** ☐ YES ☐ NO

Blood glucose at which the parent/guardian should be notified: Low: _____ High: _____

Blood glucose target range: _____ **Basal rates & boluses (meals/snacks/corrections) programmed?** ☐ YES ☐ NO

Student to check blood sugar before: ☐ Meals ☐ PE ☐ Recess ☐ Snacks ☐ Other: _____

Insulin dosage: Student to receive carbohydrate bolus: ☐ All before eating ☐ ½ before ½ after eating ☐ Other: _____

☐ See Blood Sugar/Carbohydrate/Insulin Chart attached if needed. ☐ Other dosing protocol attached

☐ Parent/guardian may decrease insulin by _____ units or increase insulin by _____ units without a new LHCP signed order.

DISASTER PLAN: _____

Student's Level of Pump/Blood Glucose Monitoring Skills

☐ **Student Totally Independent in all areas listed below and understands not to share supplies/medication.**

Skill	Independent	Needs Assistance	Skill	Independent	Needs Assistance
2. Independently counts carbohydrates			9. Fills reservoir or cartridge and primes tubing		
3. Gives correct bolus for carbohydrates consumed			10. Inserts infusion set		
4. Calculates and administers correction bolus			11. Trouble shoots all alarms		
5. Sets temporary basal rate			12. Recognizes signs/symptoms of site infection.		
6. Disconnects pump if necessary			**Blood Glucose Testing**		
7. Reconnects pump at infusion site			1. Student tests blood glucose		
8. Gives injection with syringe/pen			2. Student needs verification of blood glucose # by staff.		

Hypoglycemia:

Blood glucose below 45: _____

Blood glucose 45-65: _____

Blood glucose 65-80: _____

Blood glucose greater than 80 with symptoms: _____

Repeat Test after 15 minutes. If blood sugar is still less than 80, repeat treatment and continue to notify parent.

Hyperglycemia: Contact parent/guardian if blood sugar is greater than desired range.

Ketones: Check ketones if blood glucose is greater than _____, and notify parent/guardian.

☐ Student should go home if ketones are moderate or large.

Exercise (recess/PE) plan: ☐ Student to have 15 grams of carbohydrates before ☐ PE ☐ Recess.

End of school day: ☐ Student should not ride bus or walk home if blood sugar is below _____.

The above named student is authorized to use an insulin pump and medication in accordance with the instructions indicated above for the current school year.

►**LHCP Signature:** _____ LHCP Printed Name: _____ Date: _____

Parent/guardian: The insulin pump and all supplies are to be furnished by me. I understand that my signature indicates my understanding that reasonable care will be exercised in supporting the usage of the pump at school. The school accepts no responsibility for adverse reactions when the pump is used in accordance with the LHCP's directions. I also understand the importance of being available for consultation and support with my student's insulin pump.

►**Parent/Guardian Signature:** _____ Date: _____

►**Student signature if totally independent:** _____ Date: _____

RN Signature/Date: _____