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:** _____