| DIABETES – Insulin Pump/Smart Pen Addendum to IHP<br>Utah Department of Health & Human Services/<br>Utah State Board of Education | | | School Year: | Picture |
|---|---|---|---|---|
| Student: | DOB: | Grade: | School: | |
| Parent: | Phone: | | Email: | |
| School Nurse: | School Phone: | | Fax or Email: | |

| STUDENT DIABETES MANAGEMENT SKILLS | Needs Assistance | Needs Supervision | Independent |
|---|---|---|---|
| Identifying feelings of hypoglycemia | | | |
| Checking blood glucose | | | |
| Independently counts carbohydrates | | | |
| Entering info into pump/smart pen | | | |

**INSULIN PUMP INFORMATION**

| Type of pump/Smart Pen: | Type of CGM: | Type of insulin: |
|---|---|---|

Insulin to carb ratio: ___unit for every ___ grams of carbohydrates before meals and snacks.

Correction dose: ___unit for every ___ mg/dl for blood glucose above ___ mg/dl.

Times to bolus: ☐ Before meals ☐ After the meal ☐ Other (specify):

If Pump or Set Malfunctions: NOTIFY SCHOOL NURSE AND PARENT IMMEDIATELY.
Insulin should be given by Injection

**SPECIAL CONSIDERATIONS** (PE, School Parties or Snacks, Field Trips, Academic testing)

PE: ☐ Check BG before PE ☐ _____ gram carb (free) snack before PE ☐ Other (specify):
☐ Do not exercise if BG is below _____mg/dl or symptomatic of hyperglycemia

School parties or snacks: ☐ Give insulin per pump calculations ☐ Student to save snack for lunchtime
☐ No coverage for snacks/parties ☐ Student to take snack home ☐ Parent will provide alternate snack
☐ Other (specify):

Field Trips: Parent and school nurse must be notified of field trips in advance so proper planning and training can be accomplished.
Please specify instructions:

Academic Testing:
☐ Student may reschedule academic testing with teacher, as needed, if blood glucose is below __ or over __
☐ Other (specify):

☐ Other considerations (specify):

**WHEN HYPERGLYCEMIA OCCURS OTHER THAN AT LUNCHTIME**

Instructions for hyperglycemia (select all that apply):

☐ Give correction dose per pump/smart pen calculation (correction doses at times other than meals per pump/smart pen calculations only)
☐ Allow unrestricted access to the bathroom
☐ Notify parent/guardian
☐ Give extra water and/or non-sugar-containing drinks (not fruit juices)

**PARENT ACKNOWLEDGEMENT**

☐ I understand settings on the pump are established by the student's healthcare provider and entered by the parent/guardian. School staff will not adjust pump settings.

☐ I understand if I adjust insulin doses delivered during school hours that I am responsible for contacting provider and requesting an updated prescriber order be sent to the school.

| Parent Signature: | Date: |
|---|---|