

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:** _____