PLANO INDEPENDENT SCHOOL DISTRICT
District Health
Insulin Pump Physician Orders

Student Name:_____ID#: _____
Brand of Pump:_____Type of Insulin in pump:_____
Current infusion set:_____IV Prep or Skin Tac: _____ Y or _____N

Basal Rate:
The basal rate is set by physician order and programmed in to the pump by the physician or parent. The school nurse does not make changes to the basal rate.

Medication:
1. Rapid acting insulin (specify type)_____prior to lunch infused via insulin pump.
2. Lunch - Insulin-to Carbohydrate Ratio: 1unit insulin per_____grams carbohydrate.
3. Insulin Sensitivity Factor: 1 unit lowers glucose _____milligrams / deciliter.
    a. The insulin sensitivity factor represents the correction dosage of insulin to be administered. It is given in addition to the meal bolus of insulin.
    b. The correction dosage is calculated using the current blood glucose value minus the target glucose. Most pumps calculate this dosage as the blood glucose value is entered.
4. Target Glucose:_____to_____milligrams / deciliter

Insulin / Carbohydrate Ratio(s) and times:

Meal	# of Units	Per Gm CHO	Meal	# of Units	Per Gm CHO
Breakfast	_____Units	_____CHO	PM Snack	_____Units	_____CHO
AM Snack	_____Units	_____CHO	Dinner	_____Units	_____CHO
Lunch	_____Units	_____CHO	HS Snack	_____Units	_____CHO

Student pump abilities/skills: Check appropriate column: Needs assistance?

Skill			
Counting Carbohydrates	❒ Yes	❒ No	
Bolus correct amount for carbs consumed	❒ Yes	❒ No	❒ Via pump
Calculate and administer corrective bolus	❒ Yes	❒ No	❒ Via pump
Calculate and set temporary basal rate	❒ Yes	❒ No	
Disconnect and/or reconnect pump at infusion site	❒ Yes	❒ No	
Prepare reservoir and tubing	❒ Yes	❒ No	
Insert infusion set	❒ Yes	❒ No	
Troubleshoot alarms and malfunctions	❒ Yes	❒ No	
Suspend and/or Resume pump	❒ Yes	❒ No	

Physician Signature:_____Date:_____
Physician Printed Name:_____Phone:_____

I consent for the District's designee, including District medical professionals, to share/obtain my student's health related information with the medical health professional or health care provider identified below, in order to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other PISD form requesting school health care services. I understand that school related health services will not be provided to my student without my required consent, as outlined herein.

Parent / Guardian Signature_____Date: _____

