

**Pump Addendum**
**Student Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

**Insulin Pump Info:**

<b>Type of Pump:</b>	<b>Insulin in Pump:</b>
<b>Insulin to Carb Ratio:</b>	<b>Correction Factor:</b>

**Time to Bolus:**

Before Meal <input type="checkbox"/>	After Meal <input type="checkbox"/>	½ way into Meal <input type="checkbox"/>	Before Snack <input type="checkbox"/>	Other:
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- Check Blood Glucose level before the meal or snack  Per Fingerstick  Per CGM
- Enter the blood glucose value into the pump
- Count the grams of carbohydrates in the food eaten or to be eaten
- Enter the grams of carbohydrates into the pump
- The **pump will calculate the prescribed amount of insulin**
- Deliver the bolus by pressing the designated button(s) on the pump
- If bolus given prior to meal, do not administer more than 10 min before eating

**The settings on the pump are established by the student's healthcare provider and are not to be changed by school personnel.**

**Contact Parent/ Guardians if symptoms of:** Soreness, redness or bleeding at infusion site, dislodged infusion set, repeated alarms, leakage at connection to pump or infusion site, pump malfunction.

<b>If Pump or Set Malfunctions: NOTIFY SCHOOL NURSE AND PARENT IMMEDIATELY</b> <ul style="list-style-type: none"> <li>• Insulin may need to be given by injection</li> <li>• When pump malfunctions: Use pump calculator or School Nurse and/or parent will do calculation.....</li> <li>• Insulin to carb Ratio: Breakfast: _____ Lunch: _____ Snack: _____</li> </ul>
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**Additional Information:**

- Parents should notify the school nurse (at or before the beginning of the school day) of any adjustments made to basal and/ or bolus rates on the insulin pump so the school staff can be on alert to any reactions to insulin dosage change.
- School staff will not adjust pump settings.
- Safety features for the insulin pump should always be active while the student is at school

Pump plan has been reviewed and signed by:

Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Health aide: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse/District Nurse: \_\_\_\_\_ Date: \_\_\_\_\_