DRAGONFLY HEART CAMP FORM FOR STUDENTS WITH INSULIN PUMPS

Participant: _____ Date of Birth: _____
Medical Doctor_____Phone:_____

CONTACT INFORMATION

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell: _____
Pump Resource Person: _____ Phone: _____
Other Emergency Contact: _____

PUMP MANAGEMENT

Type of pump: _____ When did Pump Therapy start? _____
Type of Insulin: _____

Basal rates: _____ 12am to _____ Comment: _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

** Also complete the Management of Diabetes at DHC Orders for correction formulas and carb ratios **

Hyperglycemia:

_____ Pump site should be changed if blood glucose is 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 not independent Child lock on? yes no

PUMP SUPPLIES

Extra supplies needed include: infusion sets, reservoir/cartridges, insertion device, insulin vial & syringes, meter strips, lancets, batteries
*Ensure that all supplies with an expiration date are not expired and pharmacy & manufacturer labels are intact

DISASTER PLAN

Follow insulin orders as on management form Insulin doses as follows: _____
Other: _____

Health Care Provider's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____