Highline School District

Authorization for Insulin Pump at School

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP)
(e.g., MD, DO, ARNP, DDS, etc.)

Type of Pump	Type of Insulin in Pump
Type of Infusion Set	
Carbohydrate to Insulin Ratio	
Blood Glucose Correction Factor	
Blood Sugar check with Insulin Bolus ☐ Before lunch ☐ Before snack ☐ Other: _____	

Student Pump Skills					
Skill	**Yes**	**No**	**Skill**	**Yes**	**No**
1. Independently counts carbs	☐	☐	7. Reconnects pump at infusion site	☐	☐
2. Gives correct bolus for carbs consumed	☐	☐	8. Gives injection with a syringe if necessary	☐	☐
3. Calculates and administers correction bolus	☐	☐	9. Fills reservoir or cartridge and primes tubing	☐	☐
4. Sets basal rate	☐	☐	10. Inserts infusion set	☐	☐
5. Sets temporary basal rate	☐	☐	11. Troubleshoots all alarms	☐	☐
6. Disconnects pump if necessary	☐	☐			

The above-named student is authorized to use an Insulin Pump and medication in accordance with the instructions indicated above from (date): _____ to (date): _____
(not to exceed current school year).

LHP's Signature: _____ Date: _____

LHP's Name: _____

Phone Number: (_____) _____

Fax Number: (_____) _____

(Stamp)

PARENT/GUARDIAN PERMISSION FOR INSULIN ADMINISTRATION AND INSULIN PUMP USAGE

The insulin pump and all supplies are to be furnished by me. I understand that my signature indicates my understanding that reasonable care will be exercised in supporting the usage of the pump at school. The school accepts no responsibility for adverse reactions when the pump is used in accordance with the licensed health professional's directions. I also understand the importance of being available for consultation and support with my student's insulin pump.

Note: This authorization is good for the current school year only

Signature of Parent/Guardian: _____ Date: _____

Home phone: _____ Work phone: _____ Cell phone: _____

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Pump Supplies for School Required of Parents

1. Blood glucose meter with strips, lancet device with lancets
2. Urine ketone strips
3. Insulin syringes
4. Antibacterial skin cleanser or alcohol wipes
5. Insulin Pump reservoirs or cartridges
6. Insulin Pump Infusion sets
7. Transparent dressings, if used
8. Insulin Pump Batteries
9. Insertion device, if used
10. Bottle of quick acting insulin in refrigerator, labeled with student's name
11. Source of quick acting sugar for treating low blood glucose
12. Carbohydrate snack
13. Copy of basal rates and bolus dosing

24-Hour Help Phone Numbers:

Medtronic MiniMed	1-800-826-2099
Deltec, Cozmo	1-800-826-9703
Animas Corporation	1-877-767-7373