

PARENT'S REQUEST TO TREAT DIABETES AT SCHOOL
FOR COMPLETION BY PARENT/GUARDIAN

Name of Student: _____ D.O.B: ____/____/____
(LAST) (FIRST) (MI)
Name of School: _____ Grade: _____ School Year: _____

In order for my child to receive treatment in school, I agree to the following:

- All prescription medication will have a physician's signed order fully completed for each school year.
- The prescription medication will be in a container labeled by the pharmacist or physician with:

<i>Name of child.</i>	<i>Name of the medication.</i>	<i>Dosage, route and time of administration.</i>
<i>Name of physician.</i>	<i>Prescription date and expiration date.</i>	<i>Conditions for proper storage.</i>
- The medication will be brought to school by an adult.
- The physician will be called if a question arises about my child's medication.
- The first dose of this medication (except for Glucagon) has been given without problems.

Having read the above conditions, I request Anne Arundel County School Health Services personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that this procedure will be performed using standard nursing procedures. If the procedure is uncomplicated and my child's condition is stable; the school nurse may, at her discretion, teach unlicensed personnel this procedure. School or health personnel may assist toward independence in care if indicated.

Signature of Parent/Guardian: _____ Date: _____

Relationship to student: _____
Phone Number: (H) _____ (W) _____ Other _____
Address: _____

AUTHORIZED HEALTH CARE PROVIDER'S WRITTEN AUTHORIZATION

Please check all boxes that apply and complete orders: Begin services on _____ End Services on _____

1. Blood Glucose Testing

- Before am snack Before lunch Before PE 2 hours after a correction dose For suspected hypoglycemia/hyperglycemia

2. Hypoglycemia - TREAT ACCORDING TO HEALTH CARE ACTION PLAN WHEN SYMPTOMATIC OR WHEN BLOOD GLUCOSE IS LESS THAN 70.

- Glucagon injection _____ dosage, SQ/IM, for loss of consciousness, seizures or inability to swallow, if RN or LPN is available.

3. Hyperglycemia - TREAT ACCORDING TO HEALTH CARE ACTION PLAN.

4. Insulin

Brand of insulin _____

- Give _____ units of insulin SQ at lunch. Insulin dose based on carbohydrate intake: Give _____ units of insulin SQ per _____ gms of carbohydrates at lunch. Correction factor: At lunchtime give _____ units of insulin SQ for every _____ mg/dl above _____ mg/dl.

- Correction scale SQ as follows: Use correction scale at lunchtime and _____
Blood Glucose from _____ to _____ mg/dl = _____ Units Blood Glucose from _____ to _____ mg/dl = _____ Units
Blood Glucose from _____ to _____ mg/dl = _____ Units Blood Glucose from _____ to _____ mg/dl = _____ Units
Blood Glucose from _____ to _____ mg/dl = _____ Units Blood Glucose from _____ to _____ mg/dl = _____ Units

- Student is independent in insulin self-administration (school nurse and parent must verify competency).

5. Insulin Pump

Type of pump: _____ Type of insulin: _____

Bolus Administration times: _____

Please note: Pump users will need bolus insulin at prescribed times. Refer to #4 for bolus insulin orders for pump users.

- Additional orders: _____

Physician's Signature: _____ Date: _____

Original signature/NO stamps

Physician's Name (Printed): _____

Address: _____

Telephone Number: _____

Order Reviewed _____ R.N. Date _____