



DIABETES HEALTH CARE ACTION PLAN AND AUTHORIZATION FOR MEDICATION ADMINISTRATION

Student's

Photo

Dear Parent or Guardian:

The Lynchburg City Schools attempts to discourage administration of medication during school hours, and request whenever possible medication doses be scheduled other than school hours. Recognizing that this is not always possible, we will cooperate in giving medication that must be given during school time. Our regulations include:

1. Written orders using this form from a physician, detailing the name of the medication, dosage, route, and time interval of medication to be taken and plan of care.
2. Using this form, the signature of the parent or guardian requesting that the school district comply with the physician's order and plan of care
3. Medication must be brought to school by the parent or guardian in a container appropriately labeled by the pharmacy.

TO BE COMPLETED BY PARENT:

Child's Name _____ DOB _____ School _____ Grade _____

Parent/Guardian _____ Phone (H) _____ Phone (W) _____ Phone (Cell) _____

Address _____ City _____ Zip _____

Emergency contact _____ Relationship _____ Phone _____

Emergency contact _____ Relationship _____ Phone _____

Name of physician _____ Office phone _____

SYMPTOMS OF LOW BLOOD SUGAR: Shakiness, headache, hunger, changes in vision, tiredness, increase in heart rate, nervousness, inability to concentrate, irritability, confusion, combativeness, poor motor coordination, seizures

SYMPTOMS OF HIGH BLOOD SUGAR: Increased thirst, increased hunger, dry mouth, frequent urination, fatigue (weak, tired feeling) blurred vision, numbness or tingling of hands or feet, loss of consciousness (rare)

EMERGENCY MANAGEMENT: LOW BLOOD SUGAR

1. Check blood sugar, if possible. Do not leave the student alone.
2. Give a source of instant sugar (by mouth if conscious and can swallow). Examples: 1/2 cup fruit juice; 1/2 cup milk;
3. 6 oz. regular soda; 2 packets granulated sugar.
4. If student is unable to swallow, administer cake icing on inside of cheek.
5. If symptoms improve, provide a more substantial snack, such as peanut butter crackers.
6. IF SYMPTOMS DO NOT IMPROVE within 15 minutes, call 911. Notify the parent, then the physician.
7. IF THE STUDENT IS or BECOMES UNCONSCIOUS:
 - Call 911 *Administer Glucagon intramuscularly to outer side of thigh muscle.
 - Call the parent, then the student's physician.

Persons trained to administer glucagons: 1. _____ 2. _____

Physician and Parent Signature Required. Please turn to the other side to complete and sign.

Thank You!

TO BE COMPLETED PHYSICIAN:

1. DAILY MANAGEMENT

- (1) _____
- (2) _____
- (3) _____
- (4) _____
- (5) _____

2. DIET

Specific Instructions:: _____

Breakfast: _____ **Lunch:** _____
AM Snack: _____ **PM Snack** _____

Student does not require monitoring of food choices
Student requires monitoring of food choices

Student Meal Time(s) @ school _____ & _____

3. INSULIN ADMINISTRATION

Scheduled Insulin Dosing: _____ units _____ insulin
daily at _____ a.m. / p.m.
Administer _____ units _____ insulin for a BS > _____
 Utilize Sliding Scale for administration of insulin.

4. SLIDING SCALE INSULIN DOSING

INSULIN TPYE: _____
Give _____ **units insulin if BS** _____
Give _____ **units insulin if BS** _____
Give _____ **units insulin if BS** _____

5. EXERCISE

_____ No Restrictions
_____ DO NOT exercise if blood sugar is > _____ or < _____
Time of Gym or Recess(es): _____

6. BLOOD GLUCOSE MONITORING

(Please check all that apply)

- Student is to monitor blood sugar at _____ am/pm while at school; _____ PRN if symptomatic.
- BS monitoring to be done before meals. Location of glucometer at school: _____
- Special Instructions: _____
- Student is able to perform glucometry independently. _____ Student requires supervision with glucometer

I have prescribed the medication(s) listed above and reviewed this plan of care for the student. The plan is in accordance with the student's medical management.

Physician Signature

Date

Current School Year (please check)

PARENTAL CONSENT

I give my permission for school personnel to administer prescribed medication listed above and provide emergency treatment to my child. I understand that it is my responsibility to furnish this medication. I agree to notify the school if a change in my child's condition occurs. I agree to allow the information on the Health Care Plan to be shared with the adult's responsible for my child's care. I have read and understood, and do now support the Health Care Plan as outlined above. I hereby release the Lynchburg School Board, its employees, and agents from any claim or liability connected with such reliance. I am aware that should I move to another attendant zone in Lynchburg City I will need to work with the new school to continue with the above Health Care Plan for my child.

Signature of Parent or Legal Guardian

Date

School Nurse/ Health Assistant

Date