



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: ½ cup fruit juice; ½ 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) _____	
<p style="text-align: center;">2. DIET</p> <p>Specific Instructions:: _____</p> <p>_____</p> <p>Breakfast: _____ Lunch: _____</p> <p>AM Snack: _____ PM Snack: _____</p> <p>___ Student does not require monitoring of food choices</p> <p>___ Student requires monitoring of food choices</p> <p>___ Student Meal Time(s) @ school _____ & _____</p>	<p style="text-align: center;">3. INSULIN ADMINISTRATION</p> <p>Scheduled Insulin Dosing: _____ units _____ insulin daily at _____ a.m. / p.m.</p> <p>Administer _____ units _____ insulin for a BS > _____</p> <p><input type="checkbox"/> Utilize Sliding Scale for administration of insulin.</p>
<p style="text-align: center;">4. SLIDING SCALE INSULIN DOSING</p> <p>INSULIN TPYE: _____</p> <p>Give ___ units insulin if BS _____</p> <p>Give ___ units insulin if BS _____</p> <p>Give ___ units insulin if BS _____</p>	<p style="text-align: center;">5. EXERCISE</p> <p>___ No Restrictions</p> <p>___ DO NOT exercise if blood sugar is > _____ or < _____</p> <p>Time of Gym or Recess(es): _____</p>
<p style="text-align: center;">6. BLOOD GLUCOSE MONITORING</p> <p style="text-align: center;"><i>(Please check all that apply)</i></p> <p><input type="checkbox"/> Student is to monitor blood sugar at _____ am/pm while at school; _____ PRN if symptomatic.</p> <p><input type="checkbox"/> BS monitoring to be done before meals. Location of glucometer at school: _____</p> <p><input type="checkbox"/> Special Instructions: _____</p> <p><input type="checkbox"/> Student is able to perform glucometry independently. ___ Student requires supervision with glucometer</p>	

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**