Intermediate School District 917
Authorization and Request for Administration of Medications:
Blood Glucose Testing and Insulin Needs

Student _____ **Birth Date** _____ **School Year** _____
Primary Dx_____ **ICD-10** _____
Dx_____ **ICD-10** _____ **Dx**_____ **ICD-10** _____
I request that my child receive the following medication(s) and procedure(s) under the supervision of the Licensed School Nurse. I understand that I must provide equipment for the procedure(s) below.

1. Blood glucose testing:
- ❑ Before snack
- ❑ Before lunch
- ❑ 2 hours after lunch
- ❑ 2 hours after a correction dose
- ❑ For suspected hypoglycemia (as noted by student or an observer)
  Target range for blood glucose _____

2. Hypoglycemia: Blood glucose less than _____
- ❑ Self treatment of mild lows
- ❑ Assistance for all lows
- ❑ Provide extra protein and carb snack after treating lows or feed snack/meal early (if scheduled within an hour)
- ❑ Permission to use glucose gel inside cheek, even if unconscious
- ❑ Glucagon injection IM (for severe hypoglycemia) _____ 0.5 mgm _____ 1 mgm

3. Hyperglycemia:
- ❑ If blood sugar greater than _____, initiate insulin administration order
- ❑ If blood glucose greater than _____ or exhibits symptoms of ketosis, check ketones
- ❑ Check urine ketones
- ❑ Check blood ketones

4. Meal Plan:
Snacks/meals:
- ❑ Mandatory
- ❑ At student's discretion
- ❑ AM snack time _____
- ❑ PM snack time _____
- ❑ Lunch time _____
- ❑ Other _____

Extra food allowed:
- ❑ Parent's discretion
- ❑ Student's discretion

5. Exercise (Check and complete all that apply):
Liquid and solid carb sources must be available before, during and after all exercise. No exercise is permitted if most recent blood glucose is < 80.
Eat _____ gms CHO for vigorous exercise:
- ❑ Before
- ❑ Every 30 minutes during
- ❑ After
- ❑ No exercise when blood glucose is greater than _____ or ketones present

6. Authorized Health Care Provider Verification:
Student can self-perform the following procedures (parent and school nurse must verify competency.
- ❑ Blood glucose testing
- ❑ Measuring insulin
- ❑ Injecting insulin
- ❑ Determining insulin dose
- ❑ Independently operating insulin pump
- ❑ Other _____

7. Insulin orders (Complete only if insulin is needed at school):
Brand name and type: _____
Administration times (Fill in times for only those that apply):
- ❑ Breakfast _____
- ❑ AM snack _____
- ❑ Lunch _____
- ❑ PM snack _____
- ❑ Other _____

Insulin administration via:
- ❑ Syringe and vial
- ❑ Insulin pump
- ❑ Insulin pen
- ❑ Other _____

Food/Bolus doses:
- ❑ Standard lunch time dose _____
- ❑ Insulin-to-carbohydrate ratio _____ # unit(s) insulin per 15 grams carbohydrate (1CHO)
- ❑ Correction calculation (complete only those which apply):
  Give _____ unit(s) for every _____ mg/dl above _____ mg/dl
  Decrease correction by _____ % unit (s) if PE or increased activity is anticipated after correction dose, or last dose was given less than 2 hours before

OR

- ❑ Written sliding scale as follows:
  Blood glucose from _____ to _____ = _____ Units
  Blood glucose from _____ to _____ = _____ Units
  Blood glucose from _____ to _____ = _____ Units
  Blood glucose from _____ to _____ = _____ Units
- ❑ Add carb calculation/insulin dose and correction calculation for total insulin dose/bolus

8. Bus transportation:

- ❑ Blood glucose test not required before boarding bus
- ❑ Test blood glucose 10 -20 minutes before boarding bus
- ❑ Provide 15 gm glucose carb snack if blood glucose is less than _____ mg/dl
- ❑ Provide care as follows: _____

Other Needs: Specify on authorized health care provider stationary or prescription pad and attach.

Parent/Guardian Authorization

- ❑ I authorize the school nurse to contact the licensed provider as needed concerning the child's health needs, the actions of the medication(s), and clarify administration instructions.

Provider/Clinic _____ Phone # _____ Fax # _____

- I understand that parent/guardian authorization is required for any prescription medication to be given at school. Prescription medications must have a physician or licensed provider authorization.
- I understand that I must provide all medication(s) and equipment for the procedure(s).
- I understand all medications must be provided with an accurately labeled prescription container. (Please ask your health provider for the medication to be divided into two containers-one for school, & one for home) Nonprescription medications must be in an original container with label and directions.
- I will notify the school immediately if my child's health status changes or there is a cancellation of the procedure(s).
- The medication may not necessarily be administered by a school nurse. The medications may be administered by school personnel trained and supervised by a licensed school nurse.
- I have read this *Parent/Guardian Authorization* section and agree to the instructions it provides.

Parent/Guardian Signature _____ **Date** _____

Physician Authorization

- ❑ I have reviewed the medication plan and approve of it as written.
- ❑ I have reviewed the medication plan and approve of it with the attached amendments.
- ❑ List special instructions and/or possible side effects: _____
  _____
- ❑ I do not approve of the medication plan. A substitute plan is attached.
- ❑ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/her self.
  _____ Authorized Healthcare Provider Initial

Physician Signature _____ **Date** _____

The above medications may not necessarily be administered by a school nurse. The medications may be administered by school personnel trained and supervised by a licensed school nurse.

For office use only:
LSN Signature _____ Date _____
Name of Staff Routing _____ Date _____
Please check off who was routed this form ___Student File _____ IEP Manager ___ 917 LSN ___Building Nurse