39513032

HCPSS SCHOOL HEALTH SERVICES MEDICATION FORM-DIABETES MANAGEMENT

Medication Form/Physician's Order (To Be Completed by Physician/Authorized Health Care Provider)

Student Name: _____ Gender: M F Date of Birth: _____ Grade: _____ Date of Order: _____

School: _____ Order Expires End of School Year **or** (date): _____

Reason for Medication: **Diabetes Mellitus** Order valid for current year including summer school (Check if appropriate) ☐

Name of Medication: **INSULIN GLUCAGON (Circle)** Dose: _____ Strength: _____

Time to Give Medication: _____ Route: _____ Frequency of Medication: _____ Date Med. Expires: _____

Possible Side Effects: _____ Allergies: _____

Complete back for insulin sliding scale and Glucagon orders

PRINTED PHYSICIAN'S NAME	**PHYSICIAN'S SIGNATURE**	**PARENT SIGNATURE**

Medication Administration Record (For School Use Only)

Nurse Reviewed Date(s) Reviewed

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															
July																															

Name/Position	Initials	Name/Position	Initials

CODES: Chart Reason (See H.S. Manual)

X: School Closed **FT: Field Trip**
A: Absent **R: Refused**
N: None Available **O: Omitted**
NS: No Show to HR **H: Dose Held**
D/C: Medication Discontinued
L/E: Late Arrival/Early Dismissal

Diabetes Medication Order Form

Student Name: **Date:**

Insulin Sliding Scale

Type of Insulin: _____

Route (circle): **syringe** **pump** **insulin pen**

Sliding Scale:

Blood Glucose Range	Units/dose	Carb Ratio

Additional times insulin may be given: _____ Dose: _____

***If urine ketones_____ add _____ units of _____ insulin.**
(Type)

Student is able to self-administer?(circle) **YES** **NO** Comment: _____

How often should insulin vial be changed? _____

Additional comments or instructions: _____

_____

Physician/Prescriber _____ **Parent/Guardian** _____
Signature Signature

Glucagon Order

_____ Administer Glucagon _____ mg. subcutaneously for seizure, unconsciousness, or severe hypoglycemia if student is unable to swallow.

_____ Administer Cakemate (icing) or glucose gel as per Diabetes Care Plan

Call 911

Additional Instructions: _____

Physician/Prescriber _____ **Parent/Guardian** _____
Signature Signature

Glucagon Administration Record

Glucagon (_____ mg) was administered on _____ at _____ for (circle) seizure,
(date) (time)

unconsciousness, and/or severe hypoglycemia. Site of injection: _____

By: _____ _____
Signature Title