MEDICATION REQUEST/CONSENT FORM FOR DIABETES
School District of Beloit, Beloit, Wisconsin

Medications are encouraged to be administered at home by their parent/guardian whenever possible. If it is necessary for a student to receive mediations at school, on field trips, or a school sponsored activity, all appropriate portions of this form must be completed before medication can be given at school. One form for EACH medication is required.

This section to be completed by the Parent/Guardian:

Student: _____ D.O.B. _____ Date: _____

Address: _____ Phone: _____

School: _____ Grade: _____

Physician Name: _____ Address: _____ Phone: _____

Parent/Guardian Consent:

- I request and authorize that school personnel administer this medication/procedure at school.
- I will supply medication in its original, updated, pharmacy/manufacturer labeled container. (Request extra bottle from pharmacy).
- This order is in effect for the current school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school with any changes in the medication (dosage, time, route).
- I authorize the principal, assistant principal, or the school nurse to exchange information verbally or in writing with my child's Physician/Practitioner regarding this medication for any medication related concerns.
- I understand that all medication is to be transported to and from school by parent/guardian.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

DIABETES: My child is capable of checking their blood sugar and self-administering their insulin. ☐ Yes ☐ No

My child is responsible and may carry and self-administer diabetic medication in school. ☐ Yes ☐ No

Parent/Guardian Signature: _____ Phone: _____

This section to be completed by Physician/Practitioner:

Name of Medication or Procedure: Diabetic Management

Reason for Medication or Procedure: Diabetes type _____

Method: _____See additional orders

Time to be given: see additional orders Dose: see additional orders ☐ Daily ☐ As needed

This permission is valid for: ☐ Current School Year OR Dates: From _____ To _____

DIABETES: This student is capable of checking blood sugar and self-administration of insulin at school. ☐ Yes ☐ No

This student is responsible and may carry and self-administer medication in school. ☐ Yes ☐ No

The above medication is to be administered during the school day in accordance with the above instruction and agreements. I agree to accept communication about student/medication and understand that designated school personnel will give the medication. Please contact me if the following symptoms occur: _____

Physician/Practitioner Signature	Date:	Printed Name & Address of Physician/Practitioner & Phone Number

SOLICITUD DE MEDICAMENTOS Y FORMULARIO DE CONSENTIMIENTO DE DIABETES

Distrito Escolar de Beloit, Beloit, Wisconsin

Se promueve que los medicamentos sean administrados en el hogar por los padres / guardianes cuando sea posible. Si es necesario que un estudiante reciba medicina en la escuela, en los paseos, o una actividad patrocinada por la escuela, se requiere que todas las partes apropiadas de este formulario sean completadas antes de que el medicamento pueda ser administrado en la escuela. Se requiere UN formulario por CADA medicamento.

Esta sección debe ser completada por el Padre o Tutor:

Estudiante: _____ Fecha de Nacimiento: _____ Fecha: _____

Domicilio: _____ Teléfono: _____

Escuela: _____ Grado: _____

Nombre del Médico: _____ Dirección: _____ Teléfono: _____

Consentimiento del Padre o Tutor:

- Yo solicito y autorizo que el personal de la escuela administre este medicamento o procedimiento en la escuela.
- Yo suministraré el medicamento en su envase original, actualizado, con el envase etiquetado de la farmacia y fabricante. (Solicite un envase adicional en la farmacia).
- Esta orden está en vigor para el año escolar actual, al menos que se indique lo contrario.
- Yo obtendré una nueva receta del médico y notificaré a la escuela con cualquier cambio en la medicación (dosis, tiempo, método).
- Yo autorizo al director, subdirector, o la enfermera escolar a intercambiar información verbalmente o por escrito con el medico de mi hijo con respecto a este medicamento o cualquier duda relacionada con este medicamento.
- Yo entiendo que todos los medicamentos tienen que ser llevados y recogidos a la escuela por el padre o tutor.
- Yo estoy de acuerdo en eximir al Distrito Escolar, sus empleados, y agentes que están actuando dentro del ámbito de sus funciones, libremente de cualquiera y todas demandas o reclamos derivadas en la administración de este medicamento en la escuela.
- Mi firma indica que he leído y comprendo completamente la información escrita arriba.

DIABETES: Mi hijo es capaz de checar su azúcar de la sangre y administrarse su insulina en la escuela: ☐ Sí ☐ No

Mi hijo es responsable y puede llevar y administrarse el medicamento en la escuela: ☐ Sí ☐ No

Firma del padre o tutor: _____ Teléfono: _____

This section to be completed by Physician/Practitioner: (Esta Sección tiene que ser completada por el Doctor o Médico)

Name of Medication or Procedure: Diabetic Management

Reason for Medication or Procedure: Diabetes type

Method: see additional orders

Time to be given: see additional orders Dose: see additional orders ☐ Daily ☐ As needed

This permission is valid for: ☐ Current School Year OR Dates: From _____ To _____

DIABETES: This student is capable of checking blood sugar and self-administration of insulin at school. ☐ Yes ☐ No

This student is responsible and may carry and self-administer medication in school. ☐ Yes ☐ No

The above medication is to be administered during the school day in accordance with the above instruction and agreements. I agree to accept communication about student/medication and understand that designated school personnel will give the medication. Please contact me if the following symptoms occur: _____

Physician/Practitioner Signature	Date:	Printed Name & Address of Physician/Practitioner & Phone Number

ADDITIONAL MED ORDERS FOR DIABETES TO BE ADMNISTER AT SCHOOL

Name: **DOB:**

Blood Glucose monitoring: before meals and all snacks, and before sports/exercise as needed.

Urine testing for ketones: If blood glucose > _____mg/dl. And/or _____

Insulin

TIME	Humalog or Novolog
Breakfast	____ unit/____ carbohydrate + sliding scale
Lunch	____ unit/____ carbohydrate + sliding scale
Snacks	____ unit/____ carbohydrate + sliding scale

Humalog or Novolog Sliding Scale: Give ____ unit of Humalog or Novolog for every _____ mg/dl over _____mg/dl.

Hyperglycemia: Push fluids

Hypoglycemia: Blood glucose _____mg/dl or below. Patient may be asymptomatic.

Treatment: Give _____ grams of fast acting carbohydrates and check blood glucose in 15 minutes and repeat if no improvement is seen until patient improves**.**

Hypoglycemia and Unconscious: If patient is hypoglycemic and not able to take in oral carbs, then inject Glucagon 1 mg IM.

Any adjustments to insulin dosing will require a complete new order form.

Student attends Beloit Memorial High School and is competent/able to manage diabetes independently and only needs assistance if blood sugar is abnormal: □ Yes □ N

_____ _____

Parent Signature Physician Signature

_____ _____

Date Date