LAKE ZURICH COMMUNITY UNIT
School District 95

DIABETES MANAGEMENT PLAN

For School Year: _____/_____ School_____

STUDENT:_____ Birthdate:_____Grade:_____

PARENT/GUARDIAN NAME:_____PHONE:_____

ADDRESS:_____

WORK PHONE:_____CELL PHONE:_____

PARENT/GUARDIAN NAME:_____PHONE:_____

ADDRESS:_____

WORK PHONE:_____CELL PHONE:_____

In the event we are unable to reach you:

EMERGENCY PHONE CONTACT:

Name (other than parent)	Relationship	Home Phone	Cell Phone

DIABETIC MANAGEMENT(to be completed by parent with physician's assistance):

Condition: Diabetes type I_____ Diabetes type II_____ Child's age when diagnosed_____

Usual blood glucose testing times (at home):_____

Target blood glucose range:_____

Insulin type and dosage:_____

Administration times:_____

Current medications (other than insulin):_____

Time of daily blood glucose testing (at school):_____

Satisfactory blood glucose range where no action is needed:_____

For Hypoglycemia:

If blood glucose is *LESS THAN or EQUAL TO:*_____
Usual symptoms of hypoglycemia_____
Intervention:_____
_____
_____

For Hyperglycemia:

If blood glucose is *GREATER THAN or EQUAL TO:*_____
Usual symptoms of hyper glycemia:_____
Intervention:_____
_____
Should student test for ketones in urine?_____
Action if ketones are present:_____

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Other health concerns, if any:_____

Has student received diabetic education?_____

From whom?_____

Is student able to check blood glucose levels?_____Administer insulin?_____

Does student have an insulin pump?_____

Does student have a continuous glucose monitor?_____

Name of physician treating you child's diabetes:_____

_____

Physician's address city phone fax

Physician's signature:_____**Date:**_____

Additional comments:_____

_____

_____

_____

_____

_____

May the school nurse contact physician in case there are any questions or concerns in making an emergency plan for your child? Yes_____ No_____

Parent/Guardian signature:_____**Date:**_____

Received/Reviewed by:_____**Date:**_____

School nurse

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School Medication Authorization Form

To be completed by the student's parent/guardian AND PHYSICIAN and kept in the school nurse's office or, in the absence of a school nurse, the building principal's office.

Student's Name:		Birth Date:
Address:		
Home Phone:	Emergency Phone:	
School:	Grade:	Teacher:

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN: **(for all medication except asthma inhalers)**

Physician's printed name:	
Office Address:	Office Phone: Office Fax:
Medication:	
Dosage:	Frequency:
Time medication is to be administered or under what circumstances:	
Diagnosis requiring medication:	
Intended effect of this medication:	
Must this medication be administered during the school day in order to allow the student to attend school or to address the student's medical condition?	❑ ***Yes*** ❑ No
Expected side effects if any:	
Time interval for re-evaluation:	
Has student been taught to self administer this medication?	❑ Yes ❑ No
Does student have your approval to administer this medication?	❑ Yes ❑ No
Other medication student is receiving:	

Physician's Signature Date

FOR ASTHMA INHALERS ONLY, AFFIX PRESCRIPTION LABEL HERE:

COMPLETE BOTH SIDES PARENT SIGNATURE REQUIRED

By signing below, I agree:

1. That I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District 95 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of District 95), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices, and

2. To indemnify and hold harmless District 95 and its employees and agents any claims, except a claim based on willful and wanton conduct arising out of the self-administration of medication by the student.

Parent/Guardian printed name

Parent/Guardian signature

FOR PARENTS OF STUDENTS WHO SELF ADMINISTER MEDICATIONS

I authorize the School District 95 and its employees and agents, to allow my child or ward to possess and use his or her asthma medication, diabetic supplies or "Epi-Pen" (1) while in school, (2) while at a school sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property.

I verify that my child has been instructed and can self administer his/her prescribed medication in accordance with the prescribed dosage and route. Also my child is aware of potential side effects, when medication is not effective, and when additional help is needed. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's

1-18-11

COMPLETE BOTH SIDES

LAKE ZURICH COMMUNITY UNIT School District 95