Owatonna Public Schools
Health Services

Physician Authorization for Glucose Monitoring and/or Diabetes Medication(s)

Student: _____

Date of Birth: _____

The above named student has diabetes. As a person with diabetes, he/she needs to have his/her insulin, syringes, and diabetes supplies available at all times. The following orders apply:

Insulin type to be administered: _____

_____ If he/she has a severe insulin reaction and the parents have provided glucagon and if a nurse is present in the building, administer **0.5 / 1 mg glucagon** subcutaneously immediately. If a nurse is not present, call 911.

_____ He/she needs to follow a meal plan that includes fresh fruit or fruit packed in light syrup as opposed to fruit packed in heavy syrup.

_____ Child is independent with blood sugar testing and may self-administer insulin.

_____ Child requires supervision of blood sugar testing and insulin administration.

_____ Child will need assistance with blood sugar testing and administration of insulin.

_____ Administer insulin _____ minutes before lunch. The dosage is determined by the pre-meal blood sugar and the student has directions how to do this. Parents will provide base dose in writing and a copy of the supplement scale. Parents also agree to put changes in a written note to the school.

_____ Child is using a subcutaneous insulin infusion pump to deliver their insulin.

_____ Child does not take insulin.

Child is to test blood sugar: _____ upon arrival at school _____ at lunch

_____ other specific times: (please list)

Physician Signature: _____ Date: _____

Physician Name (printed): _____

Physician telephone #: _____ Fax #: _____

Parent/Guardian Authorization for Glucose Monitoring and/or Diabetes Medication

Student:

Date of Birth:

Parent/Guardian Name:

Phone Numbers: (Home) -

(Work) -

(Cell)-

1. I authorize the administration of medication during school hours as ordered by the physician.
2. I understand that this medication must be properly labeled.
3. I give permission for my child to carry/self-administer medication if ordered by the physician.
4. I understand that I must provide the supplies necessary for blood sugar testing, administration of insulin, and glucagon (if ordered) and have them available at school at all times.
5. I will provide, in writing, the base insulin dose for my child and will provide a supplement scale to the school. Written notification is needed for any changes to the base dose or supplement scale.
6. I give permission for the school health service office to consult with the above named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
7. I give permission for the school health service office to communicate with school staff about the action and side effects of this medication as well as the medical condition related to the use of the medication on a need to know basis.
8. Field trips: I give permission for the assigned teacher/responsible adult to supervise blood sugar testing and insulin administration following school protocol.

Parent Signature: _____ Date: _____

****Paperwork may be faxed directly to your child's school health office by using the fax numbers below:**

Lincoln Elementary: (507) 444-8199
McKinley Elementary: (507) 444-8299
Washington Elementary: (507) 444-8399
Wilson Elementary: (507) 444-8499

Owatonna Middle School: (507) 444-8797
Owatonna High School: (507) 444-8999
Owatonna ALC: (507) 444-8099