SAINT XAVIER HIGH SCHOOL
DIABETES MEDICATION AUTHORIZATION 2022-2023

If your son has diabetes, this form must be completed, signed, and returned to Student Services.

STUDENT NAME:_____ STUDENT I.D. #_____
Last First Middle

IF YOUR SON HAS DIABETES, BUT DOES NOT WANT TO MONITOR HIS GLUCOSE LEVEL BY HIMSELF OR TO SELF-ADMINISTER HIS DIABETES MEDICATION, COMPLETE AND SIGN ONLY THIS SECTION OF THE FORM AND HAVE YOUR SON RETURN IT TO THE STUDENT SERVICES OFFICE.

I, _____, parent/guardian of the above named student, verify that my son has Diabetes, but does not want at this time to monitor his glucose level by himself or self-administer his diabetes medication at school, at school-sponsored activities or any time he is present on Saint Xavier High School's property.

_____ _____
Parent/Guardian Signature Date

IF YOUR SON HAS DIABETES AND WANTS TO MONITOR HIS GLUCOSE LEVEL BY HIMSELF AND SELF-ADMINISTER HIS DIABETES MEDICATION AT SCHOOL, YOU AND THE STUDENT'S HEALTH CARE PRACTICIONER MUST COMPLETE AND SIGN ALL SECTIONS BELOW. YOU AND YOUR SON WILL THEN MEET WITH THE SCHOOL NURSE AND ASSISTANT PRINCIPAL FOR STUDENT LIFE TO ASCERTAIN HIS HEALTH CONDITION AND ABILITY TO SELF-ADMINISTER HIS MEDICATIONS.

I, _____, parent/guardian of the above named student, authorize Saint Xavier High School to allow him to carry with him a meter to read his glucose level as well as his diabetes medication.

_____ _____
Parent/Guardian Signature Date

I, _____, parent/guardian of the above named student, acknowledge that Saint Xavier High School shall incur no liability as a result of any injury sustained by the student to himself from monitoring his glucose level or self-administration of diabetes medication or as a result of any injury inflicted on others while monitoring his glucose level or self-administering the diabetes medication.

_____ _____
Parent/Guardian Signature Date

IF YOUR SON HAS DIABETES AND MUST SELF-ADMINISTER DIABETES MEDICATIONS AT SCHOOL, THE STUDENT'S HEALTH CARE PRACTITIONER MUST COMPLETE THE FOLLOWING SECTION AND SIGN WHERE INDICATED.

I, _____, Health Care Practitioner of the above named student, verify that this student has Diabetes, and has been instructed in self-administration of the prescribed medications listed below:

Medication	Purpose	Dosage	Circumstances under which medication must be administered	Route of Administration	Frequency of Administration

_____ _____
Health Care Practitioner Signature Date

DIABETES MANAGEMENT PLAN 2022-2023

STUDENT NAME: _____ STUDENT I.D. # _____
Last First Middle

Student's Self-Management Skills: □ **Needs Assistance** □ **Needs Supervision** □ **Independent**

□ **Recognizes Symptoms of LOW Blood Sugar**
Hungry, Weak / Shaky / Pale, Headache, Dizziness, Inattention / Confusion
Nausea / Loss of Appetite, Slurred Speech, Seizures, Clamminess / Sweating, Loss of Consciousness / Blurred Vision, Unresponsive

□ **Recognizes Symptoms of HIGH Blood Sugar**
Increased Thirst / Urination, Tired / Drowsy, Blurred Vision, Warm / Dry / Flushed Skin, Weakness / Muscle Aches
Nausea / Vomiting, Abdominal Pain, Extreme Thirst, Fruity Breath Odor, Other: _____

Insulin Administration

Type of Insulin at School: □ Fast-Acting (Humalog, Novolog, Apidra) □ Long-Acting (Lantus/Basaglar, Levemir, Other)

Insulin Delivery: □ Syringe □ Pump □ Pen □ Other: _____

Uses CGM (Brand: _____) □ Yes □ No **May use phone/receiver and CGM instead of finger sticks**

The Student's Target Blood Glucose Range is _____ to _____.

□ Use Insulin Correction Dose Formula

If BG > _____ mg/dL, give _____ unit per _____ mg/dL > _____ mg/dL

□ Use Ketone Supplementation Formula

Give additional insulin as follows: Small = _____ units; Moderate = _____ units; Large = _____ units

_____
Health Care Practitioner Signature

Notes: _____

I understand that all treatments and procedures may be performed by the student and/or authorized trained school personnel. I also understand that the school is not responsible for damage / loss of equipment. The permission for self-administration of medication shall be in effect for the school year in which it is granted and shall be renewed each following school year. (KRS 158.834)

_____ _____
Parent/Guardian Signature Date