Special Health Services Request – Iowa City Community School District

_____ _____ _____
Student Date of Birth School

PRESCRIBER/ HEALTH CARE PROVIDER STATEMENT – This student is under my medical supervision. I have prescribed the following for this student's school day:

Diabetic monitoring/ treatment:

Blood sugar monitoring _____
Blood sugar parameters _____
Treatment for low blood sugar _____
Treatment for high blood sugar _____

Insulin regimen _____
_____

Insulin pump:

Type of pump _____ Basal rates: _____ 12 a.m. to _____
_____ _____ to _____
_____ _____ to _____
Type of insulin in pump _____
Type of infusion set _____
Insulin/carbohydrate ratio_____ Correction factor _____

Emergency protocol: _____
Use frosting or glucose tablets _____
Glucagon _____

Dietary recommendations:

Constant carbohydrate diet _____
_____

Other dietary instructions _____
_____

Medications: (Please fill out medication request form) _____

Activity limitations: _____

Other recommendations or information: _____
_____
_____

_____ _____ _____
Prescriber signature Prescriber name (please print) Date

PARENT/ GUARDIAN STATEMENT – I request this special health service be provided to my child during the course of the school day. The school district has my permission to contact the prescriber if clarification is needed. I understand that qualified designated persons using a standardized procedure will perform special health services/ procedures.

_____ _____
Parent signature Date