MATAWAN- ABERDEEN SCHOOL DISTRICT

PHYSICIAN'S ORDER FOR THE ADMINISTRATION OF GLUCAGON

Part 1: To be Completed by Physician

Student's Name: _____ **D.O.B**._____

School: _____ **Grade/Teacher**: _____

Insulin: _____ **Delivery System**: □ Syringe □Pen □ Pump

Target Blood Glucose is: □ 70- 150 mg/dl □80-180mg/dl □ over 120

Usual time to check BG: □ Prior to meals and/or snacks □ Prior to exercise □ After exercise

□ Check BG for signs and symptoms of hypo/hyperglycemia

Carb Coverage:

□ For Snack _____ unit of insulin covers _____ grams of carbohydrate

□ For Lunch _____ unit of insulin covers _____ grams of carbohydrate

□ other: _____

Correction dose: (when pre-meal blood glucose>target blood glucose > target blood glucose)

□1 unit of insulin lowers blood glucose _____ mg/dl above target of _____ mg/dl

TREATMENT :

Hypoglycemia: (□< 70 mg/dl or □ < 80 mg/dl)

□ Give student 4 ounces of juice or 15 grams of fast- acting carbohydrate

□ Repeat Blood Glucose check in 15 minutes

□ Repeat the above steps if Blood Glucose remains less than □< 70 mg/dl or □ < 80 mg/dl

□ If the student becomes unconscious or is other wise unable to take anything by mouth (e.g. vomiting): administer glucagon via subcutaneous injection and call 911.

□ This student will require ____ mg of glucagon, equal to _____ units on an insulin syringe.

** **side effects of glucagon may include nausea and vomiting. Place student on side if unconscious. In addition, if student wears a pump, please suspend or disconnect insulin pump. Resume pump when student's blood glucose is > 120 mg/dl**

Hyperglycemia: (□ > 250 mg/dl or □ > 300 mg/dl)

□ If blood glucose is greater than 300 mg/dl two times within 3 hours and correction case was given, urine must be tested for ketones.

□ Please allow this student to have unrestricted bathroom privileges and request blood sugar check if bathroom use is excessive; elevated blood glucoses can cause frequent urination.

□ Drinking a non-carbohydrate containing fluid such as water is encouraged.

** **For a student with a pump: please contact student's parents whenever the blood glucose is > 300mg/dl twice in a row. Infusion set may need to be changed.**

Check all that apply:

_____ **Student has been trained and may be responsible for care of diabetes.**

_____ **Student has been trained and may be responsible for glucose monitoring.**

_____ **Student can draw up insulin & administer own insulin without supervision.**

_____ **Student can draw up insulin & administer own insulin with supervision.**

_____ **Nurse must draw up & administer insulin.**

_____ **Glucagon may be given by a designee from the above plan ON A FIELD TRIP when a nurse or parent does not attend the trip.** *In accordance with N.J.S.A. 18A:40-11-21, a designee of the school nurse who has been properly trained in the administration of glucagon will attend all field trips when the nurse or parent/guardian does not attend.*

Date: _____ Physician's Signature _____

ADMINISTRATION OF MEDICATION OF GLUCAGON
PARENT/GUARDIAN CONSENT

School Nurse:

I hereby request that the school nurse administer the medication specified on page 1 of this form as directed by my physician to my child_____. I will supply the medicine in an ORIGINAL CONTAINER and will notify the school nurse promptly of any changes in this order.

_____ _____
DATE SIGNATURE OF PARENT/GUARDIAN

Designee of School Nurse:

This is to verify that the designees of the school nurse who have been properly trained in the administration of the medication for glucagon administration and have my permission to administer said medication to my son/daughter.

_____ _____
DATE SIGNATURE OF PARENT/GUARDIAN

Waiver of Liability (*waiver must be signed by parent/guardian in order for administration of medication by nurse, designee or self-administration by pupil)*

I agree that if the procedures specified in Board Policy 5141.21 and 5141.21R regarding administration of medication are followed, the school district and its employees or agents shall incur no liability as a result of any injury.

_____ _____
DATE SIGNATURE OF PARENT/GUARDIAN

Self-Administration of Medication:

I verify that my son/daughter has my permission to self-administer the medication specified on page 1 of this form. (***CERTIFICATION MUST BE PROVIDED FROM STUDENT'S PHYSICIAN ACKNOWLEDGING PUPIL HAS BEEN INSTRUCTED IN THE PROPER METHOD OF SELF-ADMINISTRATION OF MEDICATION)***

_____ _____
DATE SIGNATURE OF PARENT/GUARDIAN

Release of Information:

I authorize the sharing of medical information about my child, _____, between my child's physician or advanced practice nurse and other heath care providers in the school. I also consent to the release of information contained in this plan to school personnel who have responsibility for or contact with my child, _____, and who may need to know this information to maintain my child's health and safety.

_____ _____
DATE SIGNATURE OF PARENT/GUARDIAN