Denison Independent School District
School Health Services Parent Request – Insulin Change Form

Student Name _____ **DOB** _____

Date of Change _____

Reviewed & Accepted, Campus Nurse (Signature and Date) _____

Parent request for additional insulin administration will not be accepted outside the guidelines of the Diabetes Management and Treatment Plan. The new insulin dose cannot exceed a 10% equivalent of original physician's orders.

The Diabetes Management and Treatment Plan from my physician, for my child, allows for parental adjustment of pre-breakfast OR pre-lunch insulin.

I am requesting the following adjustment:

◯ Fixed Dose: _____ units plus correction dose at _____.
(indicate breakfast, lunch or both)

◯ Insulin to Carbohydrate Ratio: 1 Unit Insulin per _____ Grams of Carbohydrate at _____.
(indicate breakfast or lunch)

***Insulin Correction Sliding Scale changes must be provided in writing by the healthcare provider. ***

For students with Diabetes Management Plan & Physician Orders with 10% equivalent allowable adjustment: one change may be requested per time period outlined in the DMTP. This is the only acceptable change from the original physician's order; additional adjustments require new physician orders. Addendum orders to the student's current Diabetes Management and Treatment Plan will be accepted.

Initial and sign below:

_____ *I have participated in diabetes self-management education including instruction on insulin titration skills.*

_____ *I understand that only the school's nurse may accept a change in insulin dosage.*

_____ *I request Denison ISD to adjust my child's pre-meal insulin dosage as indicated above. I authorize appropriate school staff and the prescribing healthcare provider to confidentially discuss or clarify the student's diabetes management and treatment plan and to discuss the student's response to the medication.*

_____ _____

(Parent Signature) (Date)