Chandler Unified School District #80

Diabetes Order for Prescribed Services

Student Name: _____ DOB: _____

School: _____ Grade: _____ Date: _____

Prescribed Services:

☐ Blood Glucose Monitoring
☐ Insulin Calculation and Administration
☐ Diabetic Emergency Rescue Medication (Glucagon, Baqsimi, Gvoke)
☐ Ketones Testing
☐ Identification of symptoms of High and Low Blood Glucose

Licensed Healthcare Provider Acknowledgement:

1. I have attached and approved the Diabetes Medical Management Plan (DMMP).
2. I am aware that the parent/guardian in conjunction with the school/district licensed registered nurse will train the staff/unlicensed assistive personnel to carry out the Diabetes Medical Management Plan (DMMP).
3. I am aware that parent/guardian will notify the school if procedure/medication changes.
   **Standards of care available upon request*

Licensed Healthcare Provider Name: _____ Phone No. _____
(print)

_____
Licensed Healthcare Provider Signature *Date*

Parent Acknowledgement:

1. I agree with the Diabetes Medical Management Plan (DMMP) and to provide necessary equipment/supplies properly labeled for use in school. I will work in conjunction with the school/district licensed registered nurse to provide the necessary training to the staff/ unlicensed assistive personnel.
2. I grant permission for the registered nurse to communicate directly with the above-named provider, regarding any questions or concerns with the Diabetes Medical Management Plan (DMMP).
3. I will notify the registered nurse of any/all changes in my student's Diabetic Medical Management Plan (DMMP). I will obtain verification of the changes in writing from the above healthcare provider and work with the registered nurse to provide additional training, if necessary.

Parent/Guardian Name: _____ Phone No. _____

Parent/Guardian Signature: _____ Date: _____