

Glucagon Administration-(student unconscious or unable to eat or drink)

Administer Glucagon _____ mg I.M. (Buttock, Thigh, or Arm) ****Must have a Medication Authorization Form signed****
Have student in side lying position, if not done already call 911, monitor student, document the time medication was given, dosage of medication given and location in which it was received. If student stops breathing administer rescue breaths and if pulse stops begin CPR, and contact parent/guardian

High Blood Sugar Symptoms (Teachers: Allow use of a water bottle in class and use of restroom as needed) Check ALL that apply)

Blurred Vision Frequent urination Nausea/Vomiting Drowsiness Fatigue
 Heavy Breathing Stomach ache Extreme thirst Hunger
 Other: _____

High Blood Sugar Treatment (With or without insulin pump)

Test Blood Sugar, if over _____ mg/dl student should drink large amounts of water. Retest the blood sugar in _____ minutes/hours and if symptoms persist and blood sugar remains high call parent for further instruction

Comments: _____

Ketone testing: (Check one) Testing at school No ketone testing at school-(not applicable)

Test Urine Ketones if blood sugar is over _____ mg/dl or if child is experiencing symptoms of high blood sugar
Contact parent/guardian when ketones are: _____

****If your child requires blood glucose monitoring or medication at school you must have a medication authorization form signed by you and your child’s doctor on file for THIS school year****

If medication is needed, a supply must be kept at school for your child to participate in field trips/extracurricular activities

Parent/Emergency Contact Information:

Mother	Father	Other
Name:	Name:	Name:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
Email address:	Email address:	Email address:

Authorization is hereby granted to release this information to appropriate school personnel and classroom teacher to ensure safe management of your child’s condition. If there are any questions or changes in this plan, please inform the School Nurse and/or office staff as soon as possible.

Parent/or legal guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

