GRANDVIEW R-11 SCHOOL DISTRICT
CONSENT FOR GLUCOSE MONITORING AND INSULIN ADMINISTRATION

Student Name: ______________________________ Date of Birth: ____________________
Grade: _______ Parent/Guardian Name: ____
Address: ____
Home Phone: ____________ Work Phone: ________________ Cell Phone: _______________
Physician Name: ______________________ Phone: _______________ Fax: _____________

Physician's Orders:

Self Management:

1. **Meal Plan**: Carb Counting Y / N Scheduled Snacks: Y / N Time: __________
2. **Blood Glucose Monitoring**: Meter Type: __________Time of Testing: _____________
   Testing Independently: Y / N if no assist with Lancet? Y / N Assist with obtaining blood sample? Y / N
3. **Exercise Plan**: Extra Carbohydrates for PE: Y / N Amount: __________

Insulin to be given as ordered. Insulin Regime: Sub-q__________Pump__________Pump type__________
Student may self-administer insulin at school: Y / N

Insulin Type:	**Dose**:	Time:	**Delivery Method**:
____________	__________	__________	________________
____________	__________	__________	________________

Correction Dose: __________units of insulin for every __________above __________ mg/dl
Student is able to self-adjust insulin: Y / N Comment: ______________________________
Ketone Urine Check if blood glucose is above _____: Y / N **Glucagon PRN**: dose: ______________

Licensed Prescriber's Signature: ________________________________ **Date**: ______________

Parental Release:
I, the parent/legal guardian request that glucose monitoring and insulin administration be administered as prescribed according to the licensed prescriber's orders. I would like to be notified under the following circumstances:

____ Severe low blood glucose reaction not responding to treatment within one-half hour
____ Blood glucose levels below __________
____ Blood glucose levels above __________
____ Other ____

I, the parent/legal guardian, understand that it is my responsibility to provide all required supplies for blood glucose monitoring as well as snacks and any/all items to be used in case of an insulin reaction.

I, the parent/legal guardian, release school personnel from any liability in relation to the administration of this procedure at school. If parent/legal guardian is not available during an emergency, the physician and/or ambulance may be called. I understand that any charges incurred are the responsibility of the parent/ guardian.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medial condition being treated by the medications(s).

The school nurse may share this information with appropriate school personnel _____yes _____no.

Parent/Guardian Signature: ________________________________ **Date**: ______________