

**Antelope Valley Union High School District  
Diabetes Medication Orders**

**\*\*\*\*\* PHYSICIAN SECTION \*\*\*\*\***

The Authorized Health Care Provider (signing below) must be licensed within the State of California to prescribe medication. (California Education Code 49423 and 49423.6)

<b>Student Name</b>		<b>DOB</b>	<b>Date Authorized</b>	
<b>Parent / Guardian Name</b>			<b>Work / Cell Phone</b>	
<b>Parent / Guardian Name</b>			<b>Work / Cell Phone</b>	
<b>Blood glucose testing by student</b> Before meals                      As needed		<b>Glucose Target Range</b> 70-150      90-130      100-150      100-200		
<b>Routine care of hypoglycemia</b> Self treatment Assistance required		<b>Emergency care of severe hypoglycemia</b> Glucose gel (15 grams) Glucagon Injection (1 mg.)		
<b>Hyperglycemia Care</b> Ketones checked if > 300, unless indicated Above 240		<b>Insulin Required at School</b> Not at this time Correction dose before lunch		
<b>Carbohydrate Counting (CHO)</b> Carbohydrate counting for      all meals      snacks      lunch ____ units per ____ gm				
<b>Insulin Preparation and Delivery at School</b> By student or Licensed nurse only		<b>Correction Dosage</b> ____ to ____ = ____ units      ____ to ____ = ____ units ____ to ____ = ____ units      ____ to ____ = ____ units		
If this medication and these procedures are required during school hours, these orders will be in effect until July 31 <sup>st</sup> of the summer following the school year for which they are prescribed.				
<b>Name of Authorized Health Care Provider</b>			<b>Signature</b>	
<b>Address</b>			<b>Phone</b>	
<b>***** PARENT SECTION *****</b>				
Initials required # 1, 2 and 3a or 3b				
1. I give my permission as the parent or legal guardian of the above named student to initiate this request for medication administration for my child. I acknowledge that my child may be assisted to administer this medication by a school employee trained by the District Nurse. Medications that do not have matching information on the written statement and the medication container, or are not in their original containers, will not be accepted or administered. Medication will be counted upon receipt in the health office. ____ initials				
2. In order for this medication to be available to my child at school, I give my permission for the credentialed school nurse to communicate directly with the student's physician, as may be necessary, regarding the physician's written statement or any other questions that may arise with regard to the medication. I may terminate my consent for administration of this medication at school at any time. ____ initials				
3a. My child has been trained to carry and self-administer this medication and is both responsible and capable of taking this medication, without assistance or supervision, at school. He / She is also capable and responsible to transport this medication to and from school. I release the district and school personnel from civil liability if my child suffers from an adverse reaction as a result of self-administering this medication. ____ initials				
or 3b. I request that my child be assisted and supervised during administration of this medication at school and not be permitted to administer or carry this medication without proper supervision from school personnel. ____ initials				
<b>Signature of Parent / Legal Guardian</b>				<b>Date</b>