Little Chute Area School District

Health Services

Samantha Busko, MSN, RN, School Nurse 788-7600 x2116
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Mandi Kunst, LPN (Elementary) 788-7610 x6152 Fax: 788-7847

Student's Name:	**DOB:**	**Date:**
School Attending:	**Grade:**	**Bus Student:** Yes No

Health Condition: **Diabetes – Emergency Care**

PROCEDURE

If a known diabetic student is having a seizure or becomes unresponsive i.e.) unable to talk, walk, or respond to questioning and is unable or unwilling to swallow oral sugar products:

1. Dial 911 for an ambulance to transport the student to hospital.
2. Administer glucagon if available and trained staff member is present.
3. Notify parent or emergency contact

DOSAGE

Glucagon: Inject _____ (route) Glucagon 1 mg Glucagon 0.5 mg (circle one)

Other: give: medication/dose/route/time of day _____

Possible Side Effects: _____

Direct contact shall be made with the physician should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state): _____

EMERGENCY CONTACT: Name: Phone: Relationship to student:

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Medication Consent: I hereby give permission to designated trained school personnel to give medications to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medications administration and possible adverse effects of the medication. I further agree to hold the Little Chute Area School District and LCASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary.

If self-administration is allowed, or if no authorized staff member is available, I ask that my child be permitted self-medication as authorized by my physician and myself.

I understand, as the parent/guardian, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events. .

Students health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff and other pertinent LCASD staff.

By signing you agree you have reviewed this health plan for your child and the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

Parent's Signature:	**Date:**
Physician's Signature:	**Date:**

Revised 4/2020

Principal's Initials: _____