



Little Chute Area School District

Health Services

Kara Kramer, RN, BSN, School Nurse 788-7600 x3302

Student's
Picture

325 Meulemans St Suite A, Little Chute, WI 54140

Fax (920) 788- 7603

Student's Name:	DOB:	Date:
School Attending:	Grade:	Bus Student: Yes No
Health Condition: Diabetes – Emergency Care		
<u>PROCEDURE</u> 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 student to hospital. 2. Administer glucagon if available and trained staff member is present. 3. Notify parent or emergency contact		
<u>DOSAGE</u> 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 medication 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 medication administration and possible adverse effects of the medication. I further agree to hold the Little Chute School District, and the LCSD 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 change in the above orders is necessary.		
I have reviewed the health plan for my child: The plan is correct as written _____ The plan is correct with the changes noted above _____		
Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, coaches, bus company and office staff.		
Parent's Signature:	Date:	
Physician's Signature:	Date:	

Revised 05/2014 White

Principal's Initials: _____