JONES COUNTY SCHOOL DISTRICT
PHYSICIAN'S ORDERS AND HEALTH PLAN FOR STUDENTS
WITH TYPE I AND TYPE II DIABETES

School _____

Student: _____ Grade/Teacher: _____
Date of Birth: _____ Date of Diagnosis: _____
Parent/Guardian: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Diagnosis: _____ Requires Insulin Injections: ____Yes ____No
Insulin Type: _____ Insulin Storage: _____
Diet: _____ Target range for Blood Glucose: _____
Independent in carbohydrate calculations/management? _____Yes_____No

Medical Equipment/Supplies needed at school and provided by student:

_____Glucose Monitor _____Lancet Device _____Lancets _____Alcohol Preps _____Snacks
_____Insulin _____Insulin Syringes _____Insulin Pump _____Chemstrips

Monitoring:

Will require routine glucose monitoring at school: _____Yes_____No How Often? _____
Will require assistance with monitoring: _____Yes_____No
Sliding Scale: _____
_____
_____
_____

Ketone testing and actions to take: _____

Action Plan:
Hypoglycemia: _____

Hyperglycemia: _____

Parent Signature: _____

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Physician Address: _____

Rev. 1/16

JONES COUNTY SCHOOL DISTRICT
RELEASE-TO-CARRY FORM FOR ASTHMA INHALER, ANAPHYLAXIS MEDICATION, AND/OR INSULIN SUPPLIES

Date:_____ School: _____

_____ has been instructed in the proper use of
(student's name)

_____ Medication(s).
(name of medication(s)

Diagnosis #1: _____

Name of medication #1: _____

Dosage: _____

Diagnosis #2: _____

Name of medication #2: _____

Dosage: _____

We,_____ and_____, request that
(physician) (parent/guardian)

_____
(student's full name)

be permitted to carry the asthma inhaler, anaphylaxis medication(s), and/or insulin supplies on his/her person, or to keep the asthma inhaler, anaphylaxis medication(s), and/or insulin supplies in his/her classroom or locker. He/she has been instructed in and understands the purpose, appropriate method, and frequency of use of his/her medication(s) as well as the proper method of disposal.

We, the undersigned physician and parent/guardian, absolve the school district and its employees, agents and officers of any responsibility in safeguarding our child's asthma inhaler, anaphylaxis medication(s), and/or insulin supplies.

We understand that the school district and its employees and agents will not be held liable for any injury sustained by the student that has self-administered emergency medication(s).

_____ _____
(Physician's signature) (Parent/Legal guardian signature)

_____ _____
(Principal's signature) (School Nurse's signature)

Rev 1/16