2020-2021 PHYSICIAN ORDER FOR DIABETES CARE

LEXINGTON CHRISTIAN ACADEMY
450 West Reynolds Road, Lexington KY 40503
(859) 422-5700 * www.lexingtonchristian.org

To be completed by the student's physician and returned to the applicable campus office.

Student's Name: _____ **DOB:** ___ / ___ / ___

Campus: _____ **Grade Level:** _____ **Homeroom Teacher:** _____

Parent/Guardian Name: _____ **Cell #:** _____

Parent/Guardian Name: _____ **Cell #:** _____

BLOOD SUGAR MONITORING NEEDED DURING SCHOOL HOURS:

__ Before Meal __ 2 Hours after Meal __ Before Snack __ Other: _____

Can student perform his/her own Blood Sugar Checks? __ Yes __ No

INSULIN
Type of insulin to be administered at school: _____
__ Pen __ Pump

Insulin Units to Carbohydrate Ratio: _____

Can student give his/her own injections? __ Yes __ No

Can student calculate carbs and determine correct amount of insulin? __ Yes __ No

Can student dial correct dose of insulin? __ Yes __ No

If pump, can student effectively troubleshoot problems? __ Yes __ No

I give permission for this student to check his/her own blood sugar, calculate his/her own carb intake, then determine and administer the appropriate amount of insulin ***independently.*** If student is deemed independent on the aforementioned procedures, the trained school staff member ***will not*** oversee the student's actions. __ Yes __ No

Physician's Name: _____ **Phone #:** _____

Physician's Signature: _____ **Date:** _____

PARENT/GUARDIAN STATEMENT

- **I, the undersigned Parent/Guardian of _____, authorize a trained staff member to administer the above medication to my student per the physician's instructions. I agree to furnish the necessary medication and agree to notify the school administrator immediately of any changes. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed.**

- **I, the undersigned Parent/Guardian of _____ give consent for my student to self-administer the above medication(s). I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. I agree to notify the school administrator immediately if there is a change in my student's status or physician's orders. The school administrator reserves the right to monitor the student periodically throughout the year.**

Parent's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

School Administrator's Signature: _____ **Date:** _____