

**HCPSS SCHOOL HEALTH SERVICES MEDICATION FORM-DIABETES MANAGEMENT**

**Medication Form/Physician's Order (To Be Completed by Physician/Authorized Health Care Provider)**

Student Name: \_\_\_\_\_ Gender: M F Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Order: \_\_\_\_\_  
 School: \_\_\_\_\_ Order Expires End of School Year or (date): \_\_\_\_\_  
 Reason for Medication: Diabetes Mellitus Order valid for current year including summer school ( Check if appropriate)   
 Name of Medication: INSULIN GLUCAGON (Circle) Dose: \_\_\_\_\_ Strength: \_\_\_\_\_  
 Time to Give Medication: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency of Medication: \_\_\_\_\_ Date Med. Expires: \_\_\_\_\_  
 Possible Side Effects: \_\_\_\_\_ Allergies: \_\_\_\_\_

**Complete back for insulin sliding scale and Glucagon orders**

<b>PRINTED PHYSICIAN'S NAME</b>	<b>PHYSICIAN'S SIGNATURE</b>
<b>PARENT SIGNATURE</b>	

**Medication Administration Record (For School Use Only)**

Nurse Reviewed	Date(s) Reviewed																														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
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February																															
March																															
April																															
May																															
June																															
July																															

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Name/Position	Initials	Name/Position	Initials	<b>CODES:</b> Chart Reason (See H.S. Manual)
_____	_____	_____	_____	<b>X:</b> School Closed <b>FT:</b> Field Trip
_____	_____	_____	_____	<b>A:</b> Absent <b>R:</b> Refused
_____	_____	_____	_____	<b>N:</b> None Available <b>O:</b> Omitted
_____	_____	_____	_____	<b>NS:</b> No Show to HR <b>H:</b> Dose Held
_____	_____	_____	_____	<b>D/C:</b> Medication Discontinued
				<b>L/E:</b> Late Arrival/Early Dismissal

