Richland Parish School Board
DIABETES MEDICATION ORDER

**TO BE COMPLETED BY PHYSICIAN ONLY*

STUDENT'S NAME: _____ D.O.B. _____
Name of licensed prescriber: _____ Phone: _____
Diagnosis: _____ Target blood sugar range: _____
Diet: _____ Snack Time(s): _____
Snack prior to P.E.? YES_____ NO _____

BLOOD GLUCOSE TESTING ORDER: _____
Can student do own finger stick: YES _____ NO _____
Student is: _____ Independent in monitoring his/her own blood glucose
_____ Independent in monitoring his/her own blood glucose, but requires supervision
_____ Unable to monitor his/her own blood glucose and will require assistance with procedure

*Will student require medication at school? YES _____ NO _____
MEDICATION ORDER: _____
Time(s)/circumstance for this to be given at school:
_____

Specific sliding scale orders (if applicable):

If blood sugar is this:	Give this:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Treatment for hyperglycemia: _____
Treatment for hypoglycemia: _____
Check ketones when: _____

Exercise: _____ Student can participate in regular P.E. without modifications
_____ No P.E. or exercise is permitted if ketones are present in the urine

Additional information to be provided by licensed prescriber:

1. Please list contraindications to this medication or potential adverse effects specific to this student: _____
2. List other medication(s) being taken by this student: _____
3. Insulin pump protocol (Attach if applicable):
4. IF STUDENT PASSES OUT, CALL 911 IMMEDIATELY

Signature of Authorized prescriber: _____Date: _____