Word of Life Lutheran School

HEALTH SERVICES

3545 S. 23rd Street, Milwaukee, WI 53221 Phone (414) 281-7808 Fax (414) 281-8823

Student's Name:	**DOB:**	**Date:**
School Attending:	**Grade:**	**Bus student:** Yes No
Health Condition: **Diabetes – Emergency Care**		

PROCEDURE

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.

DOSAGE

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 CALLS

1. Call 911.
2. Dr. _____ at _____
3. Emergency contact: Name/Number/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 Word of Life Lutheran School, and the Word of Life School 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.

_____**Yes** _____**No** **Authorization is hereby granted to release this information to appropriate school and bus personnel and classroom teachers.**

Parent's Signature:	**Date:**
Physician's Signature:	**Date:**
Principal's Signature:	**Date:**