PARENT'S REQUEST TO TREAT DIABETES AT RECREATION PROGRAM

FOR COMPLETION BY PARENT/GUARDIAN

Name of Participant:_____ D.O.B: ___/___/___
(LAST) (FIRST) (MI)

Name of Program:_____ Grade:_____ Session:_____

In order for my child to receive treatment in a Recreation Program, I agree to the following:

- All prescription medication will have a physician's signed order **fully** completed for each Session.
- The prescription medication will be in a container labeled by the pharmacist or physician with:
  Name of Child *Name of Medication* *Dosage, route and time of administration.*
  Name of physician *Prescription date and expiration date.* *Conditions for proper storage.*
- The Medication will be brought to the program by an adult
- The physician will be called if a question arises about my child's medication.
- The first dose of this medication (except for Glucagon) has been given without problems.

Having read the above conditions, I request Anne Arundel County Recreation & Parks Health Services personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at a recreation program. I understand that this procedure will be performed using standard nursing procedures. If the procedure is uncomplicated and my child's condition is stable; the program nurse may, at her discretion, teach unlicensed personnel this procedure. Program health personnel may assist toward independence n care if indicated.

Signature of Parent/Guardian:_____ Date:_____

Relationship to participant:_____
Phone Number: (H)_____ (W)_____ Other _____
Address: _____

AUTHORIZED HEALTH CARE PROVIDER'S WRITTEN AUTHORIZATION

Please check all boxes that apply and complete orders: Begin services on: _____. End Services On: _____.

1. Blood Glucose Testing

☐ Before am snack ☐Before lunch ☐ 2 hours after a correction dose ☐ For suspected hypoglycemia/hyperglycemia

2. Hypoglycemia

TREAT ACCORDING TO HEALTH CARE ACTION PLAN OR IF BLOOD GLUCOSE IS LESS THAN 70.

☐ Glucagon injection_____ dosage_____ route for loss of consciousness seizures or inability to swallow if RN or LPN is available

3. Hyperglycemia

TREAT ACCORDING TO HEALTH CARE ACTION PLAN.

4. Insulin

Brand of insulin _____

☐Give _____ units of insulin sq at lunch. ☐ Insulin dose based on carbohydrate intake: Give _____ units of insulin sq per ____ gms of carbohydrates at lunch. ☐ Correction factor: At lunchtime give _____ units of insulin sq for every ____ mg/dl above ___mg/dl.

☐ Correction scale sq as follows: Use correction scale at lunchtime and _____.

Blood Glucose from _____ to _____mg/dl = _____ Units Blood Glucose from _____ to _____mg/dl = _____ Units
Blood Glucose from _____ to _____mg/dl = _____ Units Blood Glucose from _____ to _____mg/dl = _____ Units
Blood Glucose from _____ to _____mg/dl = _____ Units Blood Glucose from _____ to _____mg/dl = _____ Units

☐ Student is independent in insulin self-administration (program nurse and parent must verify competency).

5. Insulin Pump

Type of pump:_____ Type of insulin:_____

Bolus Administration times: _____

Please note: Pump users will need bolus insulin at prescribed times. Refer to #3 for bolus insulin orders for pump users.

*** Please attach child's picture to this request form**

Physician's Signature: _____ Date: _____
Original/NO STAMPS

Physician's Name (Printed):_____

Address:_____

Telephone Number: _____

-Office Use Only-

Order Reviewed_____ R.N. Date _____