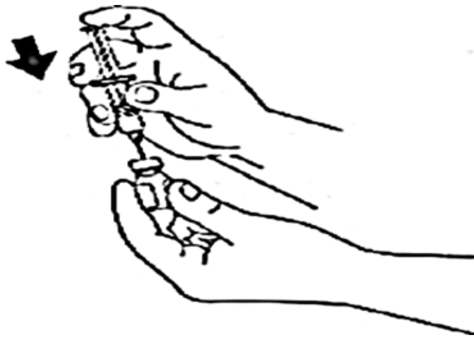
Diabetes Emergency Response
Call 911

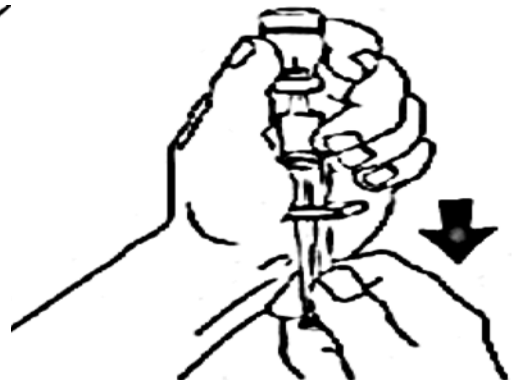
Name____Date of Birth_______________

Glucagon Injection Administration

- Use only when child is unconscious or having a seizure.
- Keep in a convenient, known place. Store in refrigerator during hot weather. Protect from freezing.
- Keep a 3cc syringe available or use the fluid-filled syringe in the Lilly Emergency Kit.
- If you have the emergency kit, skip steps 1 and 2 below.

1. **2.** **3.**





- Inject either deep into muscle (in front of leg or upper, outer arm) or into the subcutaneous fat (just as you would an insulin shot).
- Give sips of juice, sugar pop, or sugar in water initially as soon as he/she awakens. Honey may help to raise the blood sugar. After 10 minutes, encourage solid food (crackers and peanut butter or cheese sandwich, etc.)
- Notify diabetes care team of severe reaction prior to next insulin injection (so dose can be changed it needed). Complete recovery may take 1-2 hours.

Madison County School Health Program

Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School:____Date form received:_______________________

I/we acknowledge receipt of this Physician's Statement and Parent Authorization.____

Student Name:____Student age: _______________Date of Birth:________________

Grade:________________________Homeroom/Classroom:____

TO BE COMPLETED BY PARENT / GUARDIAN

**********(**MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER**)**********

Name of medication: ____

Reason for medication:____

Form of medication/treatment:____

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other ____

Instructions (Schedule and dose to be given at school:____

____

Start: ☐ Date form received ☐ Other, as specified:____

Stop: ☐ End of school year ☐ Other date/duration:____

☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes. Please describe:____

____

Special storage requirements: ☐ None ☐ Refrigerate

Other Instrructions:____

Parent or Guardian Signature____Date:______________

Health Care Provider Name____

Address:____ Phone:_______________ FAX:_____________________

I give permission for (name of child)____ is to receive the above stated medication at school according to standard school policy. I release the Madison County School Board and its employees from any claims or liability connected with its reliance on this permission.

(Parent/guardians to bring the medication in its original container.)

Date:____________________**Signature:**____ **Relationship:**__________________

Home phone:______________________ **Work phone:**____________________ **Emergency or CELL phone:**__________________________________

♦♦♦For Self-Administration and EMERGENCY ♦♦♦For Self-Administration and EMERGENCY ♦♦♦For Self-Administration and EMERGENCY♦♦♦

EMERGENCY MEDICATION AUTHORIZATION

This student is capable, responsible, and demonstrated self-administration of the above medication: **to be completed for asthmatic, diabetic or severe allergy ONLY**

☐ **Yes - Unsupervised** ☐ **Yes-Supervised** ☐ **No**

This student may carry this medication: ☐ **Yes** ☐ **No** **Any restriction(s):**____

The school nurse will delegate and train designated school personnel to give the above stated emergency medication.

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Signature:____Date____________________

Physician or Authorized Provider

******Over the counter medications can be given no more than 3 consecutive days without written orders from health care provider.** **MCBE 1 (8/09)**

Adapted from the Academy of Pediatrics