

# Blood Glucose and Insulin Procedures

_____ (Name of Student)		_____ (Grade/Teacher)	
_____ (Name of Physician or Health Care Provider)		_____ (Contact telephone #)	
_____ (Name of Medication)	_____ (Dosage)	_____ (Time)	

Medication must be dispensed following the School District Medication Policy.

## RESPONSIBILITIES FOR MONITORING BLOOD GLUCOSE AND ADMINISTERING INSULIN:

### OBSERVED

YES NO

- |       |       |   |
|-------|-------|---|
| _____ | _____ | Diabetes Checklist returned   |
| _____ | _____ | Correct use of blood glucose monitor  |
| _____ | _____ | Demonstrates knowledge of self-administration of insulin  |
| _____ | _____ | Proper timing and documentation of monitoring blood glucose   |
| _____ | _____ | Proper timing for administration of insulin   |
| _____ | _____ | Demonstrates appropriate use of supplies  |
| _____ | _____ | Follows appropriate method for disposal of supplies   |
| _____ | _____ | Keeps treatment for low/high blood sugar with own belongings in case of a secondary student in his/her own locker |
| _____ | _____ | Agrees to seek assistance from school personnel as needed   |

*The student (does/does not) demonstrate meeting the above specified responsibilities. The privilege of monitoring blood glucose and self-administration of insulin (will/will not) be allowed.*

_____ (Student's Signature)	_____ (Date)	_____ (RN's Signature/Date)
--------------------------------	-----------------	--------------------------------

Comments: \_\_\_\_\_

*My child will be responsible for carrying this medication and will self-administer. My child agrees to follow the District's procedures concerning the handling and administration of this medication.*

_____ (Parent/Guardian's Signature)	_____ (Date)
--	-----------------

Source: "Diabetes Management in the School Setting", 1998, Missouri Association of School Nurses.