Kimberly Area School District
Health Services

425 S. Washington Street • PO Box 159 • Combined Locks, WI 54113
(920) 788-7900 • FAX (920) 788-7919 • www.kimberly.k12.wi.us

Student's Name:	**DOB:**	**Date:**
School Attending:	**Grade:**	

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: give: medication/dose/route _____

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 CONTACT: Name: Phone: 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 Kimberly Area School District, and the KASD 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.

I have reviewed the health plan for my child: The plan is correct as written _____ The plan is correct with the changes noted above _____

Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, coaches, and office staff.

Elementary/Intermediate Students ONLY: Yes_____ No_____ I would also like ALL school staff to be aware of my child's health condition via powerpoint presentation at an ALL school staff inservice.

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