



NORTH BOLIVAR CONSOLIDATED SCHOOL DISTRICT

Action Request to Medical Provider by School:

Student: _____ Student #: _____ DOB: _____

Parent/Guardian: _____ Phone: _____ Date: _____

Diabetes Related Incident Observations:

Signs/Symptoms:

Low BG symptoms observed: _____

High BG Symptoms observed: _____

Required Assistance to Office

Not Responsive/Unconscious

Other: _____

Known Cause:

Too much food Incorrectly calculated carb intake _____

Too little food _____

Missed meal _____

Too much insulin Missed medication/insulin dose _____

Too little insulin _____

Increased exercise _____

Illness _____

DATA	Test Results		Treatment			
	Time	Blood Glucose	Ketones	Carb/gms	Insulin type/units/how administered	Glucagon

Details: _____

To assist this student's diabetes management, please address the following:

- Re-evaluate the medical condition of child
- Re-evaluate for Insulin dosing change
- Re-evaluate for nutrition plan change
- Re-evaluate for exercise/activity level
- Medication/supplies for school
- Glucometer for school
- Provide a signed and current Diabetes Medical Management Plan (DMMP)(may act as medication consent form)
- Counsel Student/Parents re: importance of DM mgmt. to Student's Health Survival
- Other: _____

School Nurse or Caregiver _____ Date: _____

Contact #: _____ Fax# _____

Health Care Provider Response:

New /revised Diabetes Medical Management Plan is attached Continue using current DMMP

Medication for use at home Medication/meter/strips refill called in to student's pharmacy

Other Action: _____

Health Care Provider Name/Signature: _____

Office Phone: _____ Date: _____