## Phoenix Union High School District

## DIABETES HEALTH CARE ACTION PLAN AND PHYSICIAN ORDERS DIABETES PLAN DE ACCIÓN DE ATENCIÓN MÉDICA Y PEDIDOS MÉDICOS

School Year (Año Escolar):	Grade (Grado):	Date of Birth (Fecha de Nacimiento):
Student Name (Nombre de Alumno): _		Student ID #:
Parent/Guardian Name (Nombre de Pa	ndre/Madre/Tutor):	
Cell Phone (Teléfono Cellular):	Work (Trabajo	: Home (Casa):
Physician (Nombre del Medico):		Phone (Teléfono):
medications, and supplies necessary in	providing services to the st	ble for maintenance of equipment, furnishing all equipment, cudent during school hours. The parent/guardian is also ge in orders, medications, and/or in the student's medical
and if assistance is necessary, allow procedures as ordered by the physicia	authorized trained school an/healthcare provider lice dispensing pharmacies, sh	d self-administer prescribed medications during school hours personnel to administer medications and perform medica nsed in Arizona. I authorize the school to contact my child's nould any questions, any additional orders and/or necessary rs.
medicamentos y los suministros neces	sarios para proporcionar se la enfermera de la escuela d	ntenimiento del equipo, el suministro de todo el equipo, los rvicios al alumno durante el horario escolar. El padre / tutor cada vez que haya un cambio en las órdenes, medicamentos y
horario escolar y, si es necesaria, perm procedimientos médicos según lo orde la escuela a ponerse en contacto con e	ita que el personal autoriza nado por el médico o prove I médico de mi hijo / prove	y autoadministre los medicamentos recetados durante el do de la escuela administre los medicamentos y realice los sedor de servicios de salud con licencia en Arizona. Autorizo a edores de atención médica y / o farmacias de entrega, en ecesarios para el cuidado de mi hijo durante el horario
Parent/Guardian Signature (Firma o	•	Date (Fecha)

FOR LICENSED PHYSICIAN/HEALTHCARE PROVIDER USE ONLY - PLEASE WRITE LEGIBLY

THE PHOENIX UNION HIGH SCHOOL DISTRICT IS REQUESTING YOUR ASSISTANCE IN COMPLETING THIS TWO-PAGE FORM TO IDENTIFY ANY SERVICES THAT WE MAY NEED TO PROVIDE TO THE STUDENT IN THE SCHOOL SETTING.

Students with diabetes who have a Diabetes Medical Management Plan (Diabetic Health Care Action Plan) provided by the student's parent or guardian, signed by a licensed health professional or nurse practitioner licensed in Arizona as specified by A.R.S. 15-344.01, may carry appropriate medications, monitoring equipment, and self-administer the medication during school hours. Prescribed and emergency rescue medications must be packaged in the original labeled container prepared by the pharmacy (i.e., no envelopes, foil, baggies, or any other containers) and the dispensing label must have the name of the student, name of the medication, dosage, route, and time to be administered. OTC medications (including vitamins) must be brought to school by the parent/guardian in the original container with all warnings and directions intact.

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Student Name:	School Year:
STUDENT MEDICAL DIAGNOSIS:	
DAILY CARB COUNTING AND RAPID ACTING IN	ISULIN CORRECTION/COVERAGE
Blood glucose testing is ordered to be done:	
Target Blood Sugar=	nsulin Sensitivity Factor= Carb Ratio =
MEDICATION ADMINISTRATION AND PHYSICI	AN ORDERS SEE MEDICAL DOCUMENTS/ORDERS ATTACHED
	administration time, or as needed. Medications brought to the school by the dispensed by the pharmacy and must include a current pharmacy name.
TYPE OF INSULIN DOES NOT Require Refri	geration Requires Refrigeration
student is awake, perform first aid measures fo	d/or student is presenting with signs and symptoms of low blood sugar and or the treatment of low blood sugar.
If unconscious, administer Glucagon n	ng intramuscular, protect the airway, and CALL 911 IMMEDIATELTY.
physician. If parent/guardian have provided ur	de free access to water and restroom, notify parent/guardian and/or treating ine ketone strips check for ketones. If <b>ketones are or greater</b> ; notify l/or CALL 911 immediately in emergent situations.
PHYSICIAN OR HEALTHCARE PROVIDER SIGNA	TURE REQUIRED BY THE SCHOOL
	school campus but trains authorized unlicensed assisted personnel (UAP) to care ions as ordered by the physician/healthcare provider and perform first aid
administer medications prescribed for the care handling and disposal of the equipment and m	ED to self-carry appropriate medications, monitoring equipment, and self- of diabetes. The student is be able to practice proper safety precautions for the edications that the student is authorized to use. Student misuse of medication f medications and disciplinary action by the school.
Student is <b>NOT ALLOWED</b> to self-carry, use trained school personnel.	and self-administer medication/s and will require assistance by authorized
Physician/Healthcare Provider Printed Name: _	
Physician/ Healthcare Provider Signature:	Date:
Telephone Number:	Fax Number:
Reviewed by School Nurse Date:	Signature:

Revised 4/2/18, 4/12/18, 5/10/18, 8/12/18, 5/4/20 Policy: JLCD Administering Medicines to Students