**Denison Independent School District**

**School Health Services**

**Parent Request – Insulin Change Form**

**Student Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Change** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reviewed & Accepted, Campus Nurse (Signature and Date)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Parent request for additional insulin administration will not be accepted outside the guidelines of the Diabetes Management and Treatment Plan. The new insulin dose cannot exceed a 10% equivalent of original physician’s orders.*

The Diabetes Management and Treatment Plan from my physician, for my child, allows for parental adjustment of pre-breakfast OR pre-lunch insulin.

**I am requesting the following adjustment:**

⃝ Fixed Dose: \_\_\_\_\_\_\_\_ units plus correction dose at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(indicate breakfast, lunch or both)

⃝ Insulin to Carbohydrate Ratio: 1 Unit Insulin per \_\_\_\_\_\_\_\_ Grams of Carbohydrate at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(indicate breakfast or lunch)

\*\*\*Insulin Correction Sliding Scale changes must be provided in writing by the healthcare provider. \*\*\*

**For students with Diabetes Management Plan & Physician Orders with 10% equivalent allowable adjustment: one change may be requested per time period outlined in the DMTP. This is the only acceptable change from the original physician’s order; additional adjustments require new physician orders. Addendum orders to the student’s current Diabetes Management and Treatment Plan will be accepted.**

**Initial and sign below:**

*\_\_\_\_\_\_ I have participated in diabetes self-management education including instruction on insulin titration skills.*

*\_\_\_\_\_\_ I understand that only the school’s nurse may accept a change in insulin dosage.*

*\_\_\_\_\_\_ I request Denison ISD to adjust my child’s pre-meal insulin dosage as indicated above. I authorize appropriate school staff and the prescribing healthcare provider to confidentially discuss or clarify the student’s diabetes management and treatment plan and to discuss the student’s response to the medication.*

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(Parent Signature) (Date)