

CHILDREN'S/AISD STUDENT HEALTH SERVICES

Student Name _____ DOB _____ School _____

V. School Signatures:

A. School Nurse/Clinical Manager:

I have reviewed the order for safe implementation. The date for renewal/review is _____.

School Nurse/Clinical Manager

Date

B. School Principal:

I have accepted the order to be carried out by the school nurse/trained personnel in my school.

School Principal Signature

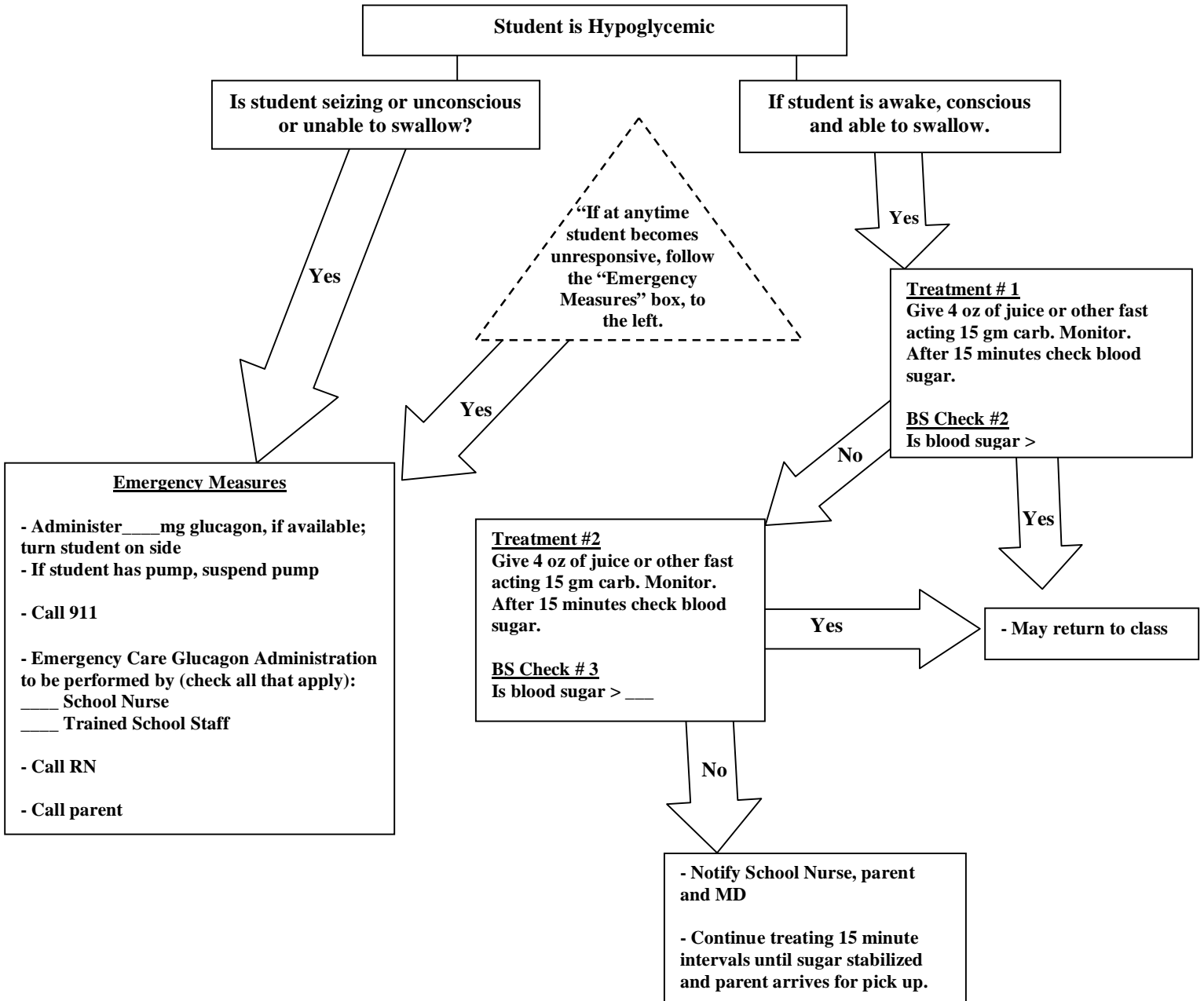
Date

Physician's Hypoglycemia Treatment Plan

Student's Name: _____ Date: _____

Physician's Name: _____

Blood sugar less than _____ will be considered hypoglycemia for this child.



**Physician's Hyperglycemia
Treatment Plan**

Student's Name: _____ Date: _____

Physician's Name: _____

Blood sugar greater than _____ will be considered hyperglycemia for this child.

