Aurora Public Schools 28J/Medicaid Services

Monitored Blood Sugar Record

Student Name: ____________________________ DOB: __________ ICD-10 Code: ______ School Year: __________School: ____________________________

Check ketones if BG>_________mg/dl

I certify that the information on this form is true and accurate and the services were provided in accordance with federal and state laws applicable to Medicaid.

Date	Time	CGM	BG	Reason for Visit	Carb Intake	Insulin Dosage	Injection Site/ Pump	Ketone Results	BG Tx	Parent Notified	Evaluation	RTC?	Will Retest @	Provider Initials	# of Service Minutes

The school health and related services listed have been determined to be necessary by a qualified healthcare professional operating within the scope of his/her practice. Delegation of nursing tasks are in accordance with the Colorado Nurse Practice Act.

Delegatee Name (printed): ______________________ Delegatee Signature: ___________________________ Delegatee Initials:______ Date: _____________

Delegatee Name (printed): ______________________ Delegatee Signature: ___________________________ Delegatee Initials:______ Date: _____________

Delegatee Name (printed): ______________________ Delegatee Signature: ___________________________ Delegatee Initials:______ Date: _____________

Name of Nurse (printed):________________________ Nurse Signature: ___________________________ Nurse Initials: _______ Date:_____________

These delegated procedures have been authorized by the RN and documented on a formal plan.