Parent Consent and Authorized Health Care Provider Authorization For Management of Diabetes at School

Pupil:	DOB:	School:	Grade:

Authorized Health Care Provider's Written Authorization: Please initial and check all boxes that apply.

1. Blood Glucose Testing

☐Before am snack ☐Before lunch ☐2 hours after lunch

☐ 2 hours after a correction dose ☐ For suspected hypoglycemia.

☐At student's descretion excluding suspected hypoglycemia

☐Only at student's discretion ☐ No blood glucose testing at school.

☐Target range for blood glucose at school _____

2. Hypoglycemia* -less than _____

☐ Self Treatment of mild lows ☐Assistance for all lows

☐ Provide extra protein & carb snack after treating lows or

☐ Feed snack/meal early (if scheduled within the hour)

☐ OK to use glucose gel inside check; even if unconscious

☐ Glucagon injection IM (for severe hypoglycemia):
____0.5 mgm _____1 mgm

3. Hyperglycemia*

☐If blood glucose > ___ initiate insulin administration order

☐If blood glucose > ___ or exhibit symptoms of ketosis, check Ketones

☐Check urine ketones ☐Check blood ketones

4. Meal Plan

☐Snacks/meals: ☐Mandatory ☐At student's discretion

☐AM snack time: _____ ☐PM snack time: _____

☐Lunch time: _____ ☐Other: _____

☐Extra food allowed: ☐Parent's discretion
☐ Student's discretion

5. Exercise (Check and/or complete all that apply):

☐Liquid and solid carb sources must be available before, duing and after all exercise.

☐No exercise if most recent blood glucose is <70

☐Eat ___gms CHO or vigorous exercise:

☐Before. ☐Every 30 minutes during. ☐After.

☐No exercise when blood glucose is > ___ or ketones are present.

6. Authorized Health Care Provider Verification: Student must self-perform the following procedures (parent and school nurse must verify competency as well):

☐Blood glucose testing ☐Measuring insulin

☐Injecting Insulin ☐Determining insuling dose

☐Independently operate insulin pump

☐Other_____

***(Refer to attached "Algorithms for Blood Glucose**

7. Insulin Orders (complete only if insulin is needed at school):

Brand name and type: _____

Administration times (fill in times for only those that apply

☐Breakfast ☐AM snack ☐Lunch ☐PM snack

☐Other: _____

Insulin administration via:

☐Syringe and vial ☐Insulin pump ☐Insulin pen

☐Other: _____

Insulin dose determined by (Check all that apply):

Food/bolus dose:

☐Standard lunchtime dose: _____

☐Insulin to carbohydrate ratio:
_____# unit(s) insulin per _____gms Carbohydrate

☐Correction Calculation

☐ Written sliding scale as follows:
Blood Glucose from ____ to ____ =_____ Units
Blood Glucose from ____ to ____ =_____ Units
Blood Glucose from ____ to ____ =_____ Units
Blood Glucose from ____ to ____ =_____ Units

☐**Add carb calculation insulin dose and correction calculation for total insulin dose/bolus**

8. Transportation:

☐Blood glucose test not required prior to boarding bus

☐Test bold glucose 10-20 minutes before boarding bus

- Provide 15 gm glucose source if blood glucose is <___mb/dl
- Provide care as follows: _____

Other: _____

9. **Field Trip**:

☐Parent will accompany child on field trip

☐Care will be provided according to IHP

Other Needs: Specify on Authorized Health Care Provider stationary or prescription page and attach.

OVER

Results" for summary of treatment procedures)	

Authorized Health Care Provider Authorization for Management of Diabetes at School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

_____ _____ _____ _____

Authorized Health Care Provider Name Signature Date Phone

☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that
(Child's Name)
_____ should be allowed to carry and use that medication by his/herself. ____ Authorized Healthcare Provider Initial
(Child's Name)

☐I request that the School Nurse provide me with a copy of the completed Individualized Healthcare Plan (IHP).

Parent Consent for Management of Diabetes at School

I (we), the undersigned, the parent(s)/guardian(s) of the above name pupil, request that the following for Management of Diabetes in school be administered to our (my) child in accordance with state laws and regulations.

I will: 1. Provide the necessary supplies and equipment.
2. Notify the school nurse if there is a change in the pupil health status or attending Authorized Health Care Provider.
3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders.

I authorize the school nurse to communicate with the Authorized Health Care Provider when necessary. I understand that I will be provided a copy of my child's completed Individual Healthcare Plan. (IHP)

Parent/Guardian Signature _____ Date _____

_____ Date _____

Reviewed by School Nurse (Signature) _____ Date _____

Reviewed by Principal (Signature) _____ Date _____

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