

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

**Pupil:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **ID#:** \_\_\_\_\_ **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 discretion excluding suspected hypoglycemia
- Only at student's discretion     No blood glucose testing at school

**Target range for blood glucose at school** \_\_\_\_\_

**2. Hypoglycemia - blood glucose less than 70**

- 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)
- O.K. to use glucose gel inside cheek
- Glucagon injection IM (for severe hypoglycemia): \_\_\_ 0.5 mgm \_\_\_ 1mgm
- Typical Symptoms: \_\_\_\_\_

**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
- Typical Symptoms: \_\_\_\_\_

**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, during and after all exercise.
- No exercise if most recent blood glucose is <70
- Eat \_\_\_\_\_gms CHO for 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 can self-perform the following procedures (parent and school nurse must verify competency as well)
- Blood glucose testing     Measuring insulin     Injecting insulin
- Determining insulin dose     Independently operating insulin pump
- Other: \_\_\_\_\_

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

**Brand name and type:** \_\_\_\_\_

**Administration times** (fill in times only for 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 doses:

- Standard lunchtime dose: \_\_\_\_\_
- Insulin to carbohydrate ratio: \_\_\_\_\_
- \_\_\_\_\_ # unit(s) insulin per \_\_\_\_\_gms Carbohydrate

**A.**  Correction Calculation (complete only those that apply)

- Give \_\_\_\_\_unit(s) for every \_\_\_\_\_mg/dl above \_\_\_\_\_mg/d
- Decrease correction by \_\_\_\_\_% unit(s) if PE or increased activity is anticipated after correction dose, or last dose was given less than 2 hours before.

**OR**

**B.**  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
- Blood Glucose from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ Units
- Blood Glucose from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ Units

- Add carb calculation, insulin dose, and correction calculation for total insulin dose/bolus (for parent use)**

**8. Bus Transportation:**

- Blood glucose test not required prior to boarding bus
- Test blood glucose 10 to 20 minutes before boarding bus
- Provide 15 gm glucose source if blood glucose is < \_\_\_\_\_mg/dl
- Provide care as follows: \_\_\_\_\_
- Other: \_\_\_\_\_

### 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)

<b>Authorized Health Care Provider (print name)</b>	<b>Signature</b>	<b>Date</b>	<b>Phone</b>
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<b>Address</b>	<b>City</b>	<b>Zip</b>
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- I have instructed \_\_\_\_\_ in the proper way to use his/her medications. It is my professional opinion that student be allowed to carry and use the medication by him/herself. \_\_\_\_\_ **Authorized Healthcare Provider Initial**

- Other Needs: Specify on Authorized Health Care Provider stationery or prescription pad and attach.**

**Provider Office Stamp**

### Parent Consent for Management of Diabetes at School

I (We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the following for Management of Diabetes in school be administered to our (my) child in accordance with California Education Code 49423.5.

I will:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in 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.

Parent/Guardian Signature _____	Date _____
Address _____	Phone Number _____

Reviewed by School Nurse (signature) _____	Date _____
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